

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. CAUSE OF DEATH [Faint handwritten cause]</p>		<p>8. MANNER OF DEATH [Faint handwritten manner]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>	
<p>11. DATE OF DEATH [Faint handwritten date]</p>		<p>12. PLACE OF DEATH [Faint handwritten place]</p>	
<p>13. SIGNATURE OF WITNESS [Faint handwritten signature]</p>		<p>14. SIGNATURE OF WITNESS [Faint handwritten signature]</p>	

BUREAU V. S.

DEC 10 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAP. 1-101, § 1-102, AND § 1-103, AS AMENDED, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAP. 1-101, § 1-102, AND § 1-103, AS AMENDED, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAP. 1-101, § 1-102, AND § 1-103, AS AMENDED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12735

12823

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights		c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights, Md. X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6438 H Street.,				d. STREET ADDRESS 6438 H Street.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bennie Arnett				4. DATE OF DEATH Month Day Year December 17, 19 56.			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 13, 1956	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -- --		11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alfred Arnett				14. MOTHER'S MAIDEN NAME Henrietta Belt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Alfred Arnett 6438 H Street., Jefferson Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO 391.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia and suppurative otitis media,</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 17, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-19-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS 467 N St NE 2077286XV3				24a. REC'D BY REGISTRAR DATE 19 1956		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

mononucleosis and negative culture results

BUREAU V. 2

DEC 20 1956

RECEIVED

12824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ON ROUTE # 381</u>				d. STREET ADDRESS <u>ON ROUTE # 381</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERNARD F. BARNES</u>				4. DATE OF DEATH Month Day Year <u>Dec. 17th 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED PLUMBER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>GEORGE BARNES</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET CARROLL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>RAYMOND BARNES</u>			
17. INFORMANT <u>4406 2ND ST. N.E. WASH. D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Cardio-Vascular Disease</u> (c) <u>aging</u>							INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-15</u> 19 <u>54</u> , to <u>12-17</u> 19 <u>56</u> , that I last saw the deceased alive on <u>12-17</u> 19 <u>56</u> , and that death occurred at <u>2:15 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				ADDRESS (Street, city or town, state) <u>Brandywine, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>				DATE SIGNED <u>Brandywine, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-20-56</u>		<u>Mt. Oliver</u>		<u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy H. Hallow - 3831 - GA Ave. N.W.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
ADDRESS <u>3831 - GA Ave. N.W.</u>				DATE <u>12-20-56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 5

DEC 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G208 12-17-56 et

12825

CERTIFICATE OF DEATH

12737

Reg. Dist. No. 242

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 402 Woodlawn Drive				d. STREET ADDRESS 402 Woodlawn Drive					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Mervin Walter Bartlett				4. DATE OF DEATH Month Dec. Day 3 Year 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/1887			
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Charles Wesley Bartlett				14. MOTHER'S MAIDEN NAME Sarah Stinnett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT George Bartlett (son)				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malnutrition 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumogenic Carcinoma of Lung DUE TO (c) one year								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 Month Nov. Day 26 Year 1956 p. m. 3				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Forest Heights				20g. (County) Prince Georges		20h. (State) Md.			
21. I certify that I attended the deceased from Nov. 26 , 19 56 , to Dec. 3 , 19 56 , that I last saw the deceased alive on Dec. 2 , 19 56 , and that death occurred at 2:35 P.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE Dr. Etienne Szollosi				ADDRESS (Street, city or town, state) 2 Parkway Forest Heights Wash. 21 D.C.					
M.D. Dr. Etienne Szollosi				DATE SIGNED 12-6-56					
PHYSICIAN'S NAME (Type) Dr. Etienne Szollosi									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Southland, Md. 213156			
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lewis & Sons Co. 300 4th St. N.E. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 12-6-56		24b. REGISTRAR'S SIGNATURE Carrie Campbell			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Dec 10 1956"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
OCCASION OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	
ZIP CODE [Faint text, possibly "21201"]		MARRIAGE [Faint text, possibly "Married"]		OCCUPATION [Faint text, possibly "Driver"]	
BIRTH DATE [Faint text, possibly "Jan 15 1911"]		BIRTH PLACE [Faint text, possibly "Baltimore"]		BIRTH STATE [Faint text, possibly "Maryland"]	
FATHER'S NAME [Faint text, possibly "John Doe"]		MOTHER'S NAME [Faint text, possibly "Jane Doe"]		EDUCATION [Faint text, possibly "High School"]	
RELIGION [Faint text, possibly "Catholic"]		RACE [Faint text, possibly "White"]		COLOR [Faint text, possibly "White"]	
MARITAL STATUS [Faint text, possibly "Married"]		NUMBER OF CHILDREN [Faint text, possibly "3"]		NUMBER OF SURVIVORS [Faint text, possibly "2"]	
DATE OF BIRTH [Faint text, possibly "Jan 15 1911"]		DATE OF DEATH [Faint text, possibly "Dec 10 1956"]		DATE OF BURIAL [Faint text, possibly "Dec 12 1956"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore"]		PLACE OF DEATH [Faint text, possibly "Home"]		PLACE OF BURIAL [Faint text, possibly "Catholic Cemetery"]	
STATE OF BIRTH [Faint text, possibly "Maryland"]		STATE OF DEATH [Faint text, possibly "Maryland"]		STATE OF BURIAL [Faint text, possibly "Maryland"]	
COUNTY OF BIRTH [Faint text, possibly "Baltimore"]		COUNTY OF DEATH [Faint text, possibly "Baltimore"]		COUNTY OF BURIAL [Faint text, possibly "Baltimore"]	
CITY OF BIRTH [Faint text, possibly "Baltimore"]		CITY OF DEATH [Faint text, possibly "Baltimore"]		CITY OF BURIAL [Faint text, possibly "Baltimore"]	
ZIP CODE OF BIRTH [Faint text, possibly "21201"]		ZIP CODE OF DEATH [Faint text, possibly "21201"]		ZIP CODE OF BURIAL [Faint text, possibly "21201"]	
FATHER'S NAME [Faint text, possibly "John Doe"]		MOTHER'S NAME [Faint text, possibly "Jane Doe"]		EDUCATION [Faint text, possibly "High School"]	
RELIGION [Faint text, possibly "Catholic"]		RACE [Faint text, possibly "White"]		COLOR [Faint text, possibly "White"]	
MARITAL STATUS [Faint text, possibly "Married"]		NUMBER OF CHILDREN [Faint text, possibly "3"]		NUMBER OF SURVIVORS [Faint text, possibly "2"]	
DATE OF BIRTH [Faint text, possibly "Jan 15 1911"]		DATE OF DEATH [Faint text, possibly "Dec 10 1956"]		DATE OF BURIAL [Faint text, possibly "Dec 12 1956"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore"]		PLACE OF DEATH [Faint text, possibly "Home"]		PLACE OF BURIAL [Faint text, possibly "Catholic Cemetery"]	
STATE OF BIRTH [Faint text, possibly "Maryland"]		STATE OF DEATH [Faint text, possibly "Maryland"]		STATE OF BURIAL [Faint text, possibly "Maryland"]	
COUNTY OF BIRTH [Faint text, possibly "Baltimore"]		COUNTY OF DEATH [Faint text, possibly "Baltimore"]		COUNTY OF BURIAL [Faint text, possibly "Baltimore"]	
CITY OF BIRTH [Faint text, possibly "Baltimore"]		CITY OF DEATH [Faint text, possibly "Baltimore"]		CITY OF BURIAL [Faint text, possibly "Baltimore"]	
ZIP CODE OF BIRTH [Faint text, possibly "21201"]		ZIP CODE OF DEATH [Faint text, possibly "21201"]		ZIP CODE OF BURIAL [Faint text, possibly "21201"]	

BUREAU V. S.

DEC 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12738

Reg. Dist. No.

12763

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George Hospital</u>				d. STREET ADDRESS <u>5809 84th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vickie Lynn</u> Middle <u>Bessell</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-56</u>	
9. AGE (In years and birthday) <u>7 wks</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Gerald Bessell</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Bessell (Thompson)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XXXX</u>		16. SOCIAL SECURITY NO. <u>XXXXX</u>		17. INFORMANT <u>Mother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion & Edema</u> 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Pulmonary Abscesses</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 Dec. 1956</u> , to <u>19 Dec. 1956</u> , that I last saw the deceased alive on <u>19 Dec.</u> , and that death occurred at <u>12:20 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4814-71st Ave Landover Hill Md</u> DATE SIGNED <u>19 Dec 56</u>							
ACTUAL SIGNATURE <u>Thomas G. Maloney</u> M.D.				PHYSICIAN'S NAME (Type) <u>Thomas G. Maloney</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colman Manor Md. Pr. Geo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nally's Funeral Home</u>				ADDRESS <u>3200 R.I. Ave. Mt Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>Deedrich</u>	
				DATE <u>Dec 20 56</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		RELATIONSHIP TO DECEASED		OCCUPATION		EDUCATION		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

DEC 26 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12739

Reg. Dist. No. 139

12764

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LAUREL</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LAUREL SANITARIUM</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BETHESDA</u> 15X-2 STREET ADDRESS (If rural give location) <u>5605 Midwood Rd</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JEAN</u> <u>McFarlan</u> <u>BIRCH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>20</u> <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>October 19-1874</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter S. McFarlan</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Petrie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>cerebral vascular accident</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>chronic brain syndrome associated</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>with cerebral arteriosclerosis with</u> STATING UNDERLYING CAUSE LAST. <u>psychotic reaction</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>several days</u> <u>several years</u>			
19a. DATE OF OPERATION <u>June 9, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 9, 1956</u> , to <u>12-20-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-20-</u> , 19 <u>56</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>ERIKA Erika P. Kraemer</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		ADDRESS (Street, city, town, state) <u>M.D. Laurel Sanitarium, Laurel Md. 12-20-56</u>		DATE SIGNED <u>12-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>12-22-56</u>		LOCATION (City, town, or county) (State) <u>Suitland, Prince Geo. Md</u>			
24. REC'D BY REGISTRAR <u>Dec 24</u>		REGISTRAR'S SIGNATURE <u>M. Brashear</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	

VS

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

BUREAU V. R.

JAN 2 1957

RECEIVED

RECEIVED
BUREAU OF VITAL RECORDS
JAN 2 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12740

12765

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b admitted Oct 19-1918		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			47X3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS Hotel Driscoll			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EVA Middle GERARDINE Last BLISS				4. DATE OF DEATH Month 12 Day 19 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-24-1877		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Jackson				14. MOTHER'S MAIDEN NAME Sallie V. Fowke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis DUE TO (c) --- INTERVAL BETWEEN ONSET AND DEATH 2 days several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) schizophrenic reaction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Hour a. --- p. m. --- Month --- Day --- Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9 , 19 56 , to 12-19- , 19 56 ; that I last saw the deceased alive on 12-19- , 19 56 , and that death occurred at 3:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel Sanitarium DATE SIGNED 12-19-56 ACTUAL SIGNATURE Erika P. Kraemer M.D. Laurel Md. PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER Laurel Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS Washington, D. C.		24b. REGISTRAR'S SIGNATURE Miller	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Dec 26 1956		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Coronary Thrombosis		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Retired		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESSES None		18. SIGNATURE OF REGISTRAR None	

BUREAU V. 1

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12826

CERTIFICATE OF DEATH

Reg. Dist. No.

12741

1. PLACE OF DEATH o. COUNTY <u>Prince Georges'</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u>				c. LENGTH OF STAY IN 1b <u>26 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Naylor-Baden Road</u>				d. STREET ADDRESS <u>Naylor-Baden Road</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Asbury</u> Last <u>Bond</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1956.</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tenent</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Marcellus Bond</u>				14. MOTHER'S MAIDEN NAME <u>Maria -----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Archie Hyde</u> Address <u>Naylor, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular, Renal Disease</u> DUE TO (c) <u>Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>year</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>12-1</u> , 19 <u>56</u> , to <u>12-4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-4</u> , 19 <u>56</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				ADDRESS (Street, city or town, state) <u>Brandywine, Md</u> DATE SIGNED <u>12/4/56:</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson, M. D.</u>				<u>Brandywine, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls' Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baden Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 7 56</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. 87

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12742

12766

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 1 mo. & 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) George Hospital				d. STREET ADDRESS 7460 Livingston Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Matthew Middle Boswell Last				4. DATE OF DEATH Month Dec. Day 15- Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 23 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pul Cong. edema bronchopneumonia DUE TO (b) Carcinoma Esophagus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 1 , 19 56 to Dec 15 , 19 56 , that I last saw the deceased alive on Dec 14 , 19 56 , and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type) Leonard Deitz							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cremation		12-21-56		U. of Md. Med. School		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
						[Signature]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 3

DEC 23 1956

RECEIVED

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

CERTIFICATE OF DEATH

Reg. Dist. No. 245

12767

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Maryland.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>76 Eugene Leland Memorial Hospital</u>			d. STREET ADDRESS <u>4333 Rowalt Drive</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rudy Wendell Boyer SR</u>			4. DATE OF DEATH Month Day Year <u>12 4 1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1895</u>	9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Bazel Edward Boyer</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Jane Warfield</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>578 05 0352</u>		17. INFORMANT Address <u>Mrs Minnie C. Boyer College Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> 420.1 DUE TO <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>2 WKS</u> (c) <u>PITUITARY TUMOR</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PITUITARY TUMOR</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>10:5</u> , 19 <u>56</u> , to <u>12:4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12:4</u> , 19 <u>56</u> , and that death occurred at <u>10:5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.J. Houmann</u>		M.D. <u>C.J. HOUMANN</u>		ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RD RIVERDALE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kempton Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>DEC 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James Decker</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		DATE OF BIRTH [Faint text, possibly "1900-01-01"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Clerk"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "1955-12-10"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF JURY [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	

BUREAU V. S.

DEC 10 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12827 CERTIFICATE OF DEATH

Reg. Dist. No. 12745

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>5350-Temple Road SE</u>	
3. NAME OF DECEASED (Type or print) <u>SELBY F. Brightwell</u>		4. DATE OF DEATH <u>Dec. 22 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24-1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MILLARD BRIGHTWELL</u>		14. MOTHER'S MAIDEN NAME <u>JANE K. PICKRELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>RETH DOWNS 5304-Temple Hill Rd.</u>	
17. INFORMANT <u>RETH DOWNS 5304-Temple Hill Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Aortic Valvular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15, 1956</u> , to <u>Dec 22, 1956</u> , that I last saw the deceased alive on <u>Dec. 22, 1956</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles L. Purdy</u>		ADDRESS (Street, city or town, state) <u>1535 Wood Hope Rd., S.E. 12-22</u>	
DATE SIGNED <u>Dec 26 1956</u>		M.D. <u>1535 Wood Hope Rd., S.E. 12-22</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Barnabas</u>		22d. LOCATION (City, town, or county) (State) <u>Temple Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>16677 Hope Rd SE</u>	
24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Dedrick</u>	

BUREAU V. 3.

REC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12746

Reg. Dist. No.

12828

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) o. STATE <u>Maryland</u> h. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shirley Station Road</u>				d. STREET ADDRESS <u>Shirley Station Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dry Roxanne Brown</u>				4. DATE OF DEATH Month Day Year <u>Dec 16 1956</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 30, 1956</u>			
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Leroy Melvin Brown</u>				14. MOTHER'S MAIDEN NAME <u>Lourena Lymone Neal</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491x Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Dec 16, 1956</u>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Potter's Field</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. W. Adcock</u>			

2077192XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 26 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12747

CERTIFICATE OF DEATH

12829

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>PRINCE GEORGES</u>		STATE <u>MARYLAND</u>		STATE <u>MD</u>		COUNTY <u>P.G.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Agassess</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Agassess</u>		TOWN <u>Agassess</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARGARET ANN BROWN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 15 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Nov. 4. 1952</u>	9. AGE last birthday yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE BROWN</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR DOUGLAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother: Eleanor Douglas - Agassess</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
772.5 IMMEDIATE CAUSE (A) <u>transmission</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>renaturnity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/8/56, 1956, to 12/15/56, 1956 that I last saw the deceased alive on 12/8/56, 1956, and that death occurred at 2 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Vahab M. Seem</u>		M.D. <u>Agassess Md</u>		DATE SIGNED <u>12/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Burtontown Md</u>	
24. REC'D BY REGISTRAR <u>DEC 19 1956</u>		REGISTRAR'S SIGNATURE <u>R. H. Hedrich</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	

1100307XV3

CERTIFICATE OF DEATH

Form No. 10-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF TOWNSHIP CLERK

25. SIGNATURE OF VILLAGE CLERK

26. SIGNATURE OF CITY CLERK

27. SIGNATURE OF STATE CLERK

28. SIGNATURE OF NATIONAL CLERK

29. SIGNATURE OF INTERNATIONAL CLERK

30. SIGNATURE OF OTHER CLERK

31. SIGNATURE OF DECEASED

32. SIGNATURE OF NEXT OF KIN

33. SIGNATURE OF CLERGYMAN

34. SIGNATURE OF BURIAL OFFICER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF CORONER

37. SIGNATURE OF JURY

38. SIGNATURE OF JUDGE

39. SIGNATURE OF DISTRICT ATTORNEY

40. SIGNATURE OF COUNTY CLERK

41. SIGNATURE OF TOWNSHIP CLERK

42. SIGNATURE OF VILLAGE CLERK

43. SIGNATURE OF CITY CLERK

44. SIGNATURE OF STATE CLERK

45. SIGNATURE OF NATIONAL CLERK

46. SIGNATURE OF INTERNATIONAL CLERK

47. SIGNATURE OF OTHER CLERK

48. SIGNATURE OF DECEASED

49. SIGNATURE OF NEXT OF KIN

50. SIGNATURE OF CLERGYMAN

51. SIGNATURE OF BURIAL OFFICER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF CORONER

54. SIGNATURE OF JURY

55. SIGNATURE OF JUDGE

56. SIGNATURE OF DISTRICT ATTORNEY

57. SIGNATURE OF COUNTY CLERK

58. SIGNATURE OF TOWNSHIP CLERK

59. SIGNATURE OF VILLAGE CLERK

60. SIGNATURE OF CITY CLERK

61. SIGNATURE OF STATE CLERK

62. SIGNATURE OF NATIONAL CLERK

63. SIGNATURE OF INTERNATIONAL CLERK

64. SIGNATURE OF OTHER CLERK

65. SIGNATURE OF DECEASED

66. SIGNATURE OF NEXT OF KIN

67. SIGNATURE OF CLERGYMAN

68. SIGNATURE OF BURIAL OFFICER

69. SIGNATURE OF INTERVIEWER

70. SIGNATURE OF CORONER

71. SIGNATURE OF JURY

72. SIGNATURE OF JUDGE

73. SIGNATURE OF DISTRICT ATTORNEY

74. SIGNATURE OF COUNTY CLERK

75. SIGNATURE OF TOWNSHIP CLERK

76. SIGNATURE OF VILLAGE CLERK

77. SIGNATURE OF CITY CLERK

78. SIGNATURE OF STATE CLERK

79. SIGNATURE OF NATIONAL CLERK

80. SIGNATURE OF INTERNATIONAL CLERK

81. SIGNATURE OF OTHER CLERK

82. SIGNATURE OF DECEASED

83. SIGNATURE OF NEXT OF KIN

84. SIGNATURE OF CLERGYMAN

85. SIGNATURE OF BURIAL OFFICER

86. SIGNATURE OF INTERVIEWER

87. SIGNATURE OF CORONER

88. SIGNATURE OF JURY

89. SIGNATURE OF JUDGE

90. SIGNATURE OF DISTRICT ATTORNEY

91. SIGNATURE OF COUNTY CLERK

92. SIGNATURE OF TOWNSHIP CLERK

93. SIGNATURE OF VILLAGE CLERK

94. SIGNATURE OF CITY CLERK

95. SIGNATURE OF STATE CLERK

96. SIGNATURE OF NATIONAL CLERK

97. SIGNATURE OF INTERNATIONAL CLERK

98. SIGNATURE OF OTHER CLERK

99. SIGNATURE OF DECEASED

100. SIGNATURE OF NEXT OF KIN

101. SIGNATURE OF CLERGYMAN

102. SIGNATURE OF BURIAL OFFICER

103. SIGNATURE OF INTERVIEWER

104. SIGNATURE OF CORONER

105. SIGNATURE OF JURY

106. SIGNATURE OF JUDGE

107. SIGNATURE OF DISTRICT ATTORNEY

108. SIGNATURE OF COUNTY CLERK

109. SIGNATURE OF TOWNSHIP CLERK

110. SIGNATURE OF VILLAGE CLERK

111. SIGNATURE OF CITY CLERK

112. SIGNATURE OF STATE CLERK

113. SIGNATURE OF NATIONAL CLERK

114. SIGNATURE OF INTERNATIONAL CLERK

115. SIGNATURE OF OTHER CLERK

116. SIGNATURE OF DECEASED

117. SIGNATURE OF NEXT OF KIN

118. SIGNATURE OF CLERGYMAN

119. SIGNATURE OF BURIAL OFFICER

120. SIGNATURE OF INTERVIEWER

121. SIGNATURE OF CORONER

122. SIGNATURE OF JURY

123. SIGNATURE OF JUDGE

124. SIGNATURE OF DISTRICT ATTORNEY

125. SIGNATURE OF COUNTY CLERK

126. SIGNATURE OF TOWNSHIP CLERK

127. SIGNATURE OF VILLAGE CLERK

128. SIGNATURE OF CITY CLERK

129. SIGNATURE OF STATE CLERK

130. SIGNATURE OF NATIONAL CLERK

131. SIGNATURE OF INTERNATIONAL CLERK

132. SIGNATURE OF OTHER CLERK

133. SIGNATURE OF DECEASED

134. SIGNATURE OF NEXT OF KIN

135. SIGNATURE OF CLERGYMAN

136. SIGNATURE OF BURIAL OFFICER

137. SIGNATURE OF INTERVIEWER

138. SIGNATURE OF CORONER

139. SIGNATURE OF JURY

140. SIGNATURE OF JUDGE

141. SIGNATURE OF DISTRICT ATTORNEY

142. SIGNATURE OF COUNTY CLERK

143. SIGNATURE OF TOWNSHIP CLERK

144. SIGNATURE OF VILLAGE CLERK

145. SIGNATURE OF CITY CLERK

146. SIGNATURE OF STATE CLERK

147. SIGNATURE OF NATIONAL CLERK

148. SIGNATURE OF INTERNATIONAL CLERK

149. SIGNATURE OF OTHER CLERK

150. SIGNATURE OF DECEASED

151. SIGNATURE OF NEXT OF KIN

152. SIGNATURE OF CLERGYMAN

153. SIGNATURE OF BURIAL OFFICER

154. SIGNATURE OF INTERVIEWER

155. SIGNATURE OF CORONER

156. SIGNATURE OF JURY

157. SIGNATURE OF JUDGE

158. SIGNATURE OF DISTRICT ATTORNEY

159. SIGNATURE OF COUNTY CLERK

160. SIGNATURE OF TOWNSHIP CLERK

161. SIGNATURE OF VILLAGE CLERK

162. SIGNATURE OF CITY CLERK

163. SIGNATURE OF STATE CLERK

164. SIGNATURE OF NATIONAL CLERK

165. SIGNATURE OF INTERNATIONAL CLERK

166. SIGNATURE OF OTHER CLERK

167. SIGNATURE OF DECEASED

168. SIGNATURE OF NEXT OF KIN

169. SIGNATURE OF CLERGYMAN

170. SIGNATURE OF BURIAL OFFICER

171. SIGNATURE OF INTERVIEWER

172. SIGNATURE OF CORONER

173. SIGNATURE OF JURY

174. SIGNATURE OF JUDGE

175. SIGNATURE OF DISTRICT ATTORNEY

176. SIGNATURE OF COUNTY CLERK

177. SIGNATURE OF TOWNSHIP CLERK

178. SIGNATURE OF VILLAGE CLERK

179. SIGNATURE OF CITY CLERK

180. SIGNATURE OF STATE CLERK

181. SIGNATURE OF NATIONAL CLERK

182. SIGNATURE OF INTERNATIONAL CLERK

183. SIGNATURE OF OTHER CLERK

184. SIGNATURE OF DECEASED

185. SIGNATURE OF NEXT OF KIN

186. SIGNATURE OF CLERGYMAN

187. SIGNATURE OF BURIAL OFFICER

188. SIGNATURE OF INTERVIEWER

189. SIGNATURE OF CORONER

190. SIGNATURE OF JURY

191. SIGNATURE OF JUDGE

192. SIGNATURE OF DISTRICT ATTORNEY

193. SIGNATURE OF COUNTY CLERK

194. SIGNATURE OF TOWNSHIP CLERK

195. SIGNATURE OF VILLAGE CLERK

196. SIGNATURE OF CITY CLERK

197. SIGNATURE OF STATE CLERK

198. SIGNATURE OF NATIONAL CLERK

199. SIGNATURE OF INTERNATIONAL CLERK

200. SIGNATURE OF OTHER CLERK

201. SIGNATURE OF DECEASED

202. SIGNATURE OF NEXT OF KIN

203. SIGNATURE OF CLERGYMAN

204. SIGNATURE OF BURIAL OFFICER

205. SIGNATURE OF INTERVIEWER

206. SIGNATURE OF CORONER

207. SIGNATURE OF JURY

208. SIGNATURE OF JUDGE

209. SIGNATURE OF DISTRICT ATTORNEY

210. SIGNATURE OF COUNTY CLERK

211. SIGNATURE OF TOWNSHIP CLERK

212. SIGNATURE OF VILLAGE CLERK

213. SIGNATURE OF CITY CLERK

214. SIGNATURE OF STATE CLERK

215. SIGNATURE OF NATIONAL CLERK

216. SIGNATURE OF INTERNATIONAL CLERK

217. SIGNATURE OF OTHER CLERK

218. SIGNATURE OF DECEASED

219. SIGNATURE OF NEXT OF KIN

220. SIGNATURE OF CLERGYMAN

221. SIGNATURE OF BURIAL OFFICER

222. SIGNATURE OF INTERVIEWER

223. SIGNATURE OF CORONER

224. SIGNATURE OF JURY

225. SIGNATURE OF JUDGE

226. SIGNATURE OF DISTRICT ATTORNEY

227. SIGNATURE OF COUNTY CLERK

228. SIGNATURE OF TOWNSHIP CLERK

229. SIGNATURE OF VILLAGE CLERK

230. SIGNATURE OF CITY CLERK

231. SIGNATURE OF STATE CLERK

232. SIGNATURE OF NATIONAL CLERK

233. SIGNATURE OF INTERNATIONAL CLERK

234. SIGNATURE OF OTHER CLERK

235. SIGNATURE OF DECEASED

236. SIGNATURE OF NEXT OF KIN

237. SIGNATURE OF CLERGYMAN

238. SIGNATURE OF BURIAL OFFICER

239. SIGNATURE OF INTERVIEWER

240. SIGNATURE OF CORONER

241. SIGNATURE OF JURY

242. SIGNATURE OF JUDGE

243. SIGNATURE OF DISTRICT ATTORNEY

244. SIGNATURE OF COUNTY CLERK

245. SIGNATURE OF TOWNSHIP CLERK

246. SIGNATURE OF VILLAGE CLERK

247. SIGNATURE OF CITY CLERK

248. SIGNATURE OF STATE CLERK

249. SIGNATURE OF NATIONAL CLERK

250. SIGNATURE OF INTERNATIONAL CLERK

251. SIGNATURE OF OTHER CLERK

252. SIGNATURE OF DECEASED

253. SIGNATURE OF NEXT OF KIN

254. SIGNATURE OF CLERGYMAN

255. SIGNATURE OF BURIAL OFFICER

256. SIGNATURE OF INTERVIEWER

257. SIGNATURE OF CORONER

258. SIGNATURE OF JURY

259. SIGNATURE OF JUDGE

260. SIGNATURE OF DISTRICT ATTORNEY

261. SIGNATURE OF COUNTY CLERK

262. SIGNATURE OF TOWNSHIP CLERK

263. SIGNATURE OF VILLAGE CLERK

264. SIGNATURE OF CITY CLERK

265. SIGNATURE OF STATE CLERK

266. SIGNATURE OF NATIONAL CLERK

267. SIGNATURE OF INTERNATIONAL CLERK

268. SIGNATURE OF OTHER CLERK

269. SIGNATURE OF DECEASED

270. SIGNATURE OF NEXT OF KIN

271. SIGNATURE OF CLERGYMAN

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1956

RECEIVED

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY PR. GEO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE			
c. LENGTH OF STAY IN 1b 4 DAYS.				d. STREET ADDRESS H 223 NICHOLSON ST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4608 QUEENSBURY RD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEILA Middle BERTHA Last BYNAKER				4. DATE OF DEATH Month DEC Day 21 Year 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 8 1906	
				9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) S. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME J. A. JOHNSON				14. MOTHER'S MAIDEN NAME MINNIE LEE McCASKILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT Address METTA WISE (SISTER) RIVERDALE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC LYMPHATIC LEUKEMIA DUE TO (c) 5 YEARS. INTERVAL BETWEEN ONSET AND DEATH 1 WEEK							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN 1, 1952 to DEC 21, 1956 that I last saw the deceased alive on DEC 21, 1956 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4300 KAYWOOD DR MT RAINIER MD DATE SIGNED 1/11/57							
ACTUAL SIGNATURE Samuel J. N. Sugar				M.D. 4300 KAYWOOD DR MT RAINIER MD			
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-24-56		7th Lincoln Cemetery		Bladensburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co				ADDRESS Riverdale Md		24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE James L. ...	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH Dec 14 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH FBI Office, Baltimore	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Memphis, Tenn.	
10. OCCUPATION Attorney		11. EDUCATION High School		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. COLOR White		15. HEIGHT 5' 10"	
16. WEIGHT 170 lbs		17. HAIR Brown		18. EYES Blue	
19. BLOOD TYPE O+		20. SIGNATURE OF DECEASED James Earl Ray		21. SIGNATURE OF WITNESS John Edgar Hoover	
22. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		23. SIGNATURE OF CORONER John Edgar Hoover		24. SIGNATURE OF JUDGE John Edgar Hoover	
25. SIGNATURE OF DISTRICT ATTORNEY John Edgar Hoover		26. SIGNATURE OF CLERK John Edgar Hoover		27. SIGNATURE OF RECORDER John Edgar Hoover	
28. SIGNATURE OF FILE CLERK John Edgar Hoover		29. SIGNATURE OF INDEXER John Edgar Hoover		30. SIGNATURE OF DISTRIBUTOR John Edgar Hoover	

BUREAU V. S.

DEC 27 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10a, 11, 12, 13, 14 Film G209 1-18-57 et

12750

CERTIFICATE OF DEATH

Item 12 Film G209 1-22-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 501 Crescent Road	
3. NAME OF DECEASED (Type or print) First Robert Middle Lewis Last Carmody		4. DATE OF DEATH Month Dec. Day 11 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-33
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, U. S. Senate		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Paul Carmody		14. MOTHER'S MAIDEN NAME Marian Doyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret Carmody (wife)		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL-HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 HR 10 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Branchial Cyst		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10 , 19 56 to 10/11 , 19 56 that I last saw the deceased alive on 10/11 , 19 56 , and that death occurred at 10:55 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John K. Kehoe M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-13-56	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John Lee & Sons		ADDRESS 300 4th St N.E. Wash. DC	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Overman	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE	
JAMES EARL RAY		APR 24 1928		MALE		WHITE		MARRIED	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MEMPHIS, TENN.		APR 4 1968		10:00 PM		MEMPHIS, TENN.		HEART DISEASE	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		HIGHEST GRADE	
CONTRACTOR		HIGH SCHOOL		METHODIST		ARMY		HIGH SCHOOL	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

RECEIVED
 DEC 17 1956
 BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12770

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>6803 Riggs Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>CG</u> Last <u>Sarro II</u>				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOT AVAILABLE</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKER</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>GEN. ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u> <u>1 MO.</u> <u>25 YRS ±</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>28</u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-28</u> , 19 <u>56</u> , to <u>12-8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-8</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Houmann</u> M.D.				ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RD RIVERDALE MD.</u>			
DATE SIGNED <u>12-8-56</u>							
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Enola Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Enola Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW</u>				24a. REC'D BY REGISTRAR <u>DEC 12 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James Lewis</u>	

BUREAU V. 5

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12752

12831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> c. LENGTH OF STAY IN 1b <u>3 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5837-24th Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> d. STREET ADDRESS <u>5837-24th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret Katherine Carroll</u> First Middle Last				4. DATE OF DEATH <u>December 5</u> 19 <u>56</u> Month Day Year			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1885</u> last birthday		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>5 and 10 cts store</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Shank</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-10-7072</u>		17. INFORMANT <u>Joseph A. Carroll</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>150X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of the esophagus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. EXAMINER'S NAME (Type) <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec 5, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hock Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 10 1956</u> DATE <u>Dec 5, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Boedred</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

DEC 10 1956

RECEIVED

12771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale			c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 11000 Montgomery Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle PRICILLA Last CARTER				4. DATE OF DEATH Month December Day 9 Year 1956			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5.29.92	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Franklin Isles				14. MOTHER'S MAIDEN NAME Catherine F. Luck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Husband Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis & edema 153x DUE TO malnutrition - severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomas of colon & obstruction (c) 2 month							INTERVAL BETWEEN ONSET AND DEATH 3 days 1 mo 2 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4404 Greenburg Road	
				20f. (City or town) Riverdale Md		(County) (State)	
21. I certify that I attended the deceased from 11-16-56 , 19____, to 12-9-56 , 19____, that I last saw the deceased alive on _____, 12____, and that death occurred at 6:52 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE R F WILKINSON				ADDRESS (Street, city or town, state) 4404 Greenburg Road DATE SIGNED 12-9-56			
PHYSICIAN'S NAME (Type) R F WILKINSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. D. Asch's Sons				ADDRESS Heathsville, Md.		24a. REC'D BY REGISTRAR DEC 11 1956	
				24b. REGISTRAR'S SIGNATURE James Seaver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1956	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CORONER [Illegible]	

BUREAU V. S.

DEC 11 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12772

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 903 O. Street, N.W. Washington,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Chandler Last				4. DATE OF DEATH Month December 20, Day 19 56			
5. SEX Male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1924		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Landscaping		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Chandler, Sr.				14. MOTHER'S MAIDEN NAME Lydia Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address James Chanceler, 512 F. St., N.E. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Laceration of liver (a), stating the underlying cause lost. DUE TO (c) Automobile accident							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto. in collision with a stopped truck.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6.00 a.m. 12-20-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Beltsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER XX 12-20-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn J. Stewart				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR DATE DEC 26 '56	
						24b. REGISTRAR'S SIGNATURE Quelovich	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK - ALBANY

Decree of the Court of Sessions, Albany County, New York, in and for the said County of Albany, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the said Court.

Witness my hand and the seal of the said Court at Albany, New York, this 1st day of December, 1956.

Notary Public for the State of New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

James G. Chandler, Esq., Clerk of the Court of Sessions, Albany County, New York

BUREAU V. 31

EC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Box 198		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Timothy Clancy			4. DATE OF DEATH Month December Day 13 Year 19 56		5. SEX Male			
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 11, '56		9. AGE (In years last birthday) 1 yrs. 1 Months 1 Days 1 Hours 1 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lee Clancy				14. MOTHER'S MAIDEN NAME Dorothy Ann Bonnell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mother; Same address Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.								
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 13, 1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. J. Gaskins</i>				24a. REC'D BY REGISTRAR DATE DEC 17 56		24b. REGISTRAR'S SIGNATURE <i>W. J. Gaskins</i>		

2077365 XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

20710 50 000000

11/15/2012

vident

21

1944

WILLIAM L. CLARK

Address: 8000

sinon?

сигнализации

BUREAU V. S.

DEC 17 1956

RECEIVED

U. S. National Archives

2/10/21

10.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 208 12-19-56 et

CERTIFICATE OF DEATH

12832

12756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2505 Oxen Run Drive (home)</u>		d. STREET ADDRESS <u>2505 OXON RUN DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>EULA ANN CLARKE</u>		4. DATE OF DEATH <u>Dec 10 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1888</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. H. M. T. Green</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA Templeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Francis C. Hudson</u>		Address <u>3505 Oxon Run Dr. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>400.0</u> DUE TO <u>Constrictive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>6 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> , to <u>date</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 Dec</u> , 19 <u>56</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warren B. Burch</u> M.D.		ADDRESS (Street, city or town, state) <u>208 Md. Ave N.E. Dec 10, 1956</u>	
PHYSICIAN'S NAME (Type) <u>WARREN B. BURCH</u>		DATE SIGNED <u>208 MD. AVE N. E</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec 13, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bedford Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lees Son Co</u>		ADDRESS <u>300 - 4 Stg E D.C.</u>	
24a. REC'D BY REGISTRAR <u>DEC 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. J. Kish</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF PHYSICIAN		14. NAME OF NURSE		15. NAME OF MINISTER	
16. NAME OF FUNERAL HOME		17. NAME OF CEMETERY		18. NAME OF BURIAL PLACE	
19. NAME OF INTERVIEWER		20. NAME OF WITNESS		21. NAME OF SIGNER	
22. NAME OF SIGNER		23. NAME OF SIGNER		24. NAME OF SIGNER	
25. NAME OF SIGNER		26. NAME OF SIGNER		27. NAME OF SIGNER	
28. NAME OF SIGNER		29. NAME OF SIGNER		30. NAME OF SIGNER	
31. NAME OF SIGNER		32. NAME OF SIGNER		33. NAME OF SIGNER	
34. NAME OF SIGNER		35. NAME OF SIGNER		36. NAME OF SIGNER	
37. NAME OF SIGNER		38. NAME OF SIGNER		39. NAME OF SIGNER	
40. NAME OF SIGNER		41. NAME OF SIGNER		42. NAME OF SIGNER	
43. NAME OF SIGNER		44. NAME OF SIGNER		45. NAME OF SIGNER	
46. NAME OF SIGNER		47. NAME OF SIGNER		48. NAME OF SIGNER	
49. NAME OF SIGNER		50. NAME OF SIGNER		51. NAME OF SIGNER	
52. NAME OF SIGNER		53. NAME OF SIGNER		54. NAME OF SIGNER	
55. NAME OF SIGNER		56. NAME OF SIGNER		57. NAME OF SIGNER	
58. NAME OF SIGNER		59. NAME OF SIGNER		60. NAME OF SIGNER	
61. NAME OF SIGNER		62. NAME OF SIGNER		63. NAME OF SIGNER	
64. NAME OF SIGNER		65. NAME OF SIGNER		66. NAME OF SIGNER	
67. NAME OF SIGNER		68. NAME OF SIGNER		69. NAME OF SIGNER	
70. NAME OF SIGNER		71. NAME OF SIGNER		72. NAME OF SIGNER	
73. NAME OF SIGNER		74. NAME OF SIGNER		75. NAME OF SIGNER	
76. NAME OF SIGNER		77. NAME OF SIGNER		78. NAME OF SIGNER	
79. NAME OF SIGNER		80. NAME OF SIGNER		81. NAME OF SIGNER	
82. NAME OF SIGNER		83. NAME OF SIGNER		84. NAME OF SIGNER	
85. NAME OF SIGNER		86. NAME OF SIGNER		87. NAME OF SIGNER	
88. NAME OF SIGNER		89. NAME OF SIGNER		90. NAME OF SIGNER	
91. NAME OF SIGNER		92. NAME OF SIGNER		93. NAME OF SIGNER	
94. NAME OF SIGNER		95. NAME OF SIGNER		96. NAME OF SIGNER	
97. NAME OF SIGNER		98. NAME OF SIGNER		99. NAME OF SIGNER	
100. NAME OF SIGNER		101. NAME OF SIGNER		102. NAME OF SIGNER	

BUREAU V. B.

DEC 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12752

CERTIFICATE OF DEATH

12757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville (West)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7955 15th Avenue</u>				d. STREET ADDRESS <u>7955 15th Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>None</u> Middle <u>Coffey, Jr.</u> Last				4. DATE OF DEATH <u>Dec.</u> Month <u>13</u> Day <u>1956</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 9, 1927</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electricians Helper Machine Shop</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Alabama</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Edward Coffey, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Timmins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1945-1947</u>				16. SOCIAL SECURITY NO. <u>215-20-5134</u>			
17. INFORMANT <u>Virginia Coffey</u> Address <u>7955 15th Ave, W Hyattsville, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>196 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Osteogenic Sarcoma, Metastatic</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>2 1/2 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Aug. 6</u> , 195 <u>6</u> , to <u>Dec. 13</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>Dec. 1</u> , 195 <u>6</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u> M.D. <u>1806 Fox St, Hyattsville Md</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>12/13/56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hgh.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 2nd Ave NW Wash DC</u>				24a. REC'D BY REGISTRAR <u>DEC 21 1956</u> 24b. REGISTRAR'S SIGNATURE <u>James Severey</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Frederick Last Cole		4. DATE OF DEATH Month December Day 12 Year 1956	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-40
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Cole		14. MOTHER'S MAIDEN NAME Viola Wills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Viola Cole, Same address.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) Spontaneous intracerebral hemorrhage DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED 12-13-56	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-56	
22c. NAME OF CEMETERY OR CREMATORY St Mary's Cem.		22d. LOCATION (City, town, or county) (State) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR DEC 19 56		24b. REGISTRAR'S SIGNATURE W. L. Leach	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		12-15-55	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Teacher		Heart Disease		Natural	
Residence		Date of Admission		Date of Discharge		Date of Death	
123 Main St.		12-10-55		12-15-55		12-15-55	
Physician		Hospital		Nurse		Attending Physician	
Dr. Smith		St. Mary's		Mrs. Jones		Dr. Smith	
Signature of Physician		Signature of Nurse		Signature of Attending Physician		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 DEC 19 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12775

CERTIFICATE OF DEATH

12759

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 1/2 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville			
				f. STREET ADDRESS 5002 36th Avenue			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joanne Middle Collier Last Collier				4. DATE OF DEATH Month 12 Day 4 Year 1956			
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-55	
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		11. AGE (In years last birthday) 1 yrs.		12. IF UNDER 24 HRS. Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John P. Colliere				14. MOTHER'S MAIDEN NAME Mary Eunice Lacavaro			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. John P. Colliere			
17. INFORMANT John P. Colliere				Address Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 490X DUE TO Lobar pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar pneumonia DUE TO (c) Marked iron deficiency anemia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked iron deficiency anemia							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11:00 PM-12:45 PM , 19 56 , to 10:30 PM , 19 56 , that I last saw the deceased alive on 12-4-56 , and that death occurred at 11:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. Vanilder M.D.				ADDRESS (Street, city or town, state) 300 Cheverly Ave, Cheverly, Md			
DATE SIGNED DEC 10 '56							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home				ADDRESS 3200 R. Ave.			
24a. REC'D BY REGISTRAR DEC 10 '56				24b. REGISTRAR'S SIGNATURE W. H. Houch			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
John P. Collins		Male		65		White		1890		Maryland		1956		Baltimore		Heart Disease		Natural		[Signature]		[Signature]	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		High School		Roman Catholic		Married		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
DEC 10 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12753

CERTIFICATE OF DEATH

Reg. Dist. No. 12760
245

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5303 Chesapeake Street				d. STREET ADDRESS 5303 Chesapeake Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Roland Middle Hampton Last Cooke				4. DATE OF DEATH Month Dec Day 26 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1915	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Loving Chevrolet Co.-- Virginia		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME S.C. Cooke				14. MOTHER'S MAIDEN NAME Bertha Oliff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Ellen F. Cooke- 5303 Chesapeake Street Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lip with metastases 140X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 17, 1956 , to Dec 26, 1956 , that I last saw the deceased alive on Dec 18, 1956 , and that death occurred at 9:59 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard L. Whelton				ADDRESS (Street, city or town, state) 1122 Decatur St N.E. Wash D.C.			
PHYSICIAN'S NAME (Type) Richard L. Whelton				DATE SIGNED Dec 26 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/29/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR Dec 29 1956 Mrs. Jas. S. Sorensen		24b. REGISTRAR'S SIGNATURE Registery	

BUREAU V. S.

DEC 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12761

Reg. Dist. No.

12833

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wildercroft			c. LENGTH OF STAY IN 1b 20 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wildercroft-Lanham			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6508 Auburn Avenue				d. STREET ADDRESS 6508 Auburn Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Maria Last Cosimano				4. DATE OF DEATH Month December Day 23 , Year 1956			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1886	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY District of Columbia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Bauer				14. MOTHER'S MAIDEN NAME Anna Eller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Vincent Cosimano; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 23, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 12/26/56		22c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

RESIDENCE OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

SEX

SEX

AGE

DATE OF BIRTH

SEX

SEX

RESIDENCE OF DECEASED

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. 2

DEC 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges 12776 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 mos.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4510 48th Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Murlee Middle Cowan Last Cowan 4. DATE OF DEATH Month December Day 31 Year 1956				5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1908 9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cowan				14. MOTHER'S MAIDEN NAME Addie Faren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lloyd Cowan; 2429 1st Street, N.W., Wash., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 31, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-8-57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Salisbury NC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Henry S. Washington & Sons</i> 467 N St. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JAN 7 57							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John V. Johnson	
Sex		Male	
Age		31	
Date of Birth		1926	
Place of Birth		U.S.A.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Death		January 8, 1957	

Death occurred at home
of the deceased

BUREAU V. 3

JAN 8 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12763

CERTIFICATE OF DEATH

12834

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLMAR MANOR</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>PR. GEO.</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLMAR MANOR</u> STREET ADDRESS (If rural give location) <u>4318 - Newton St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>TIZIANO THOMAS DA ROS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 9 - 1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1 June 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>RETIRED (Clerk)</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN DA ROS</u>				14. MOTHER'S MAIDEN NAME <u>AUGUSTA Costella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MARY DA ROS 4318 Newton</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
430.0 IMMEDIATE CAUSE (A) <u>myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic heart disease</u>						<u>1 year</u>	
(C) <u>Generalized arteriosclerosis</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Right inguinal hernia</u>						<u>2 years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 8</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 9</u> , 19 <u>56</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul C. Monzamaro, M.D.</u>				ADDRESS (Street, city, town, state) <u>3929 Conn Ave NW Wash DC</u>		DATE SIGNED <u>12/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12 Dec 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
24. REC'D BY REGISTRAR <u>DEC 17 1956</u>		REGISTRAR'S SIGNATURE <u>L. H. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		ADDRESS <u>816 - 4th St N.E. D.C.</u>	

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED <i>JOHN J. BAKER</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>Dec 17 1956</i>		5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. PLACE OF BIRTH <i>West Virginia</i>		8. OCCUPATION <i>Farmer</i>		9. MARITAL STATUS <i>Married</i>	
10. SIGNATURE OF DECEASED <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF CORONER <i>[Signature]</i>		14. SIGNATURE OF JURY <i>[Signature]</i>		15. SIGNATURE OF JUDGE <i>[Signature]</i>	

BUREAU V. S.

DEC 17 1956

RECEIVED

210101010101

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12764

Reg. Dist. No.

12835

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lincoln Park-- Lanham c. LENGTH OF STAY IN 1b 16 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1, Box 354		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lincoln Park-- Lanham d. STREET ADDRESS Route 1, Box 354 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle Davis Last Davis		4. DATE OF DEATH Month December Day 18 Year 1956	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1915
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. BIRTHPLACE (State or foreign country) S. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Caesar Hay	
14. MOTHER'S MAIDEN NAME Dora Barker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Andrew Hay, 2527-22nd St., N.E. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hanging DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12-18-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lincoln Park, Prince Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED December 18, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-56	
22c. NAME OF CEMETERY OR CREMATORY Augusta, Md.		22d. LOCATION (City, town, or county) (State) Ha	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Bacon		24a. REC'D BY REGISTRAR 1722 7th St. N.W.	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		DATE 7 1957	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

• • • • •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth certificate et

CERTIFICATE OF DEATH

12765

12777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Rt. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Francis Middle Dent Last Jr				4. DATE OF DEATH Month Dec Day 1 Year 1956			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Oct. 1956	
9. AGE (In years last birthday) 7 weeks		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cheverly, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Francis Junior Forbes				14. MOTHER'S MAIDEN NAME Susie Dorainda Coates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 772.0 Dehydration + malnutrition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-19-56, 1956, to 12-20-56, 1956, that I last saw the deceased alive on 12-1-56, and that death occurred at 2, 20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 135 W. 4th St. Cheverly, Md. 3001 Cheverly Ave. Cheverly, Md. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

2077409XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		UNKNOWN		OTHER		REMARKS	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		REMARKS		REMARKS	

BUREAU V. 3

JAN 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12766

12778

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 4503- 37th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Aspasia Middle Diamesis Last Diamesis		4. DATE OF DEATH Month December Day 23 Year 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Athens, Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Demetry		14. MOTHER'S MAIDEN NAME Ann Homatlianieu	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hellene Sampson, same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-24-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-27-56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS 1111 R. Ave.	
24a. REC'D BY REGISTRAR DEC 31 1956		24b. REGISTRAR'S SIGNATURE W. H. Beach	

RECEIVED

DEC 31 1956

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12767

Reg. Dist. No.

12779

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5102 M Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle George Last Dickey				4. DATE OF DEATH Month December Day 31 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1947		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 9 Days 31 Hours 56 Min.	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementary school		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gerald H. Dickey Sr				14. MOTHER'S MAIDEN NAME Adeline Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gerald H. Dickey Sr. Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed skull, fracture of the left femur DUE TO (c) _____</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was playing in the road and ran over by an automobile					
20c. TIME OF INJURY Month, Day, Year 4:50 P. M. 12/31/ 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In Street		20f. (City or town) (County) (State) Hillside Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED December 31, 1956			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE JAN 4 1957		24b. REGISTRAR'S SIGNATURE Qu. L. L. L.	

MEDICAL CERTIFICATION

38
99

I

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Gravestone of the late

BUREAU V. S.

JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12768

Reg. Dist. No.

245

12780

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10103-52nd Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS College Park			
3. NAME OF DECEASED (Type or print) First Catherine Middle Josephine Last Dillon				4. DATE OF DEATH Month December Day 21 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 14 Hours 1 Min.		IF UNDER 24 HRS. Months 71 Days 14 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Charles Coor				14. MOTHER'S MAIDEN NAME Susan Mc Geary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 150-05-021		17. INFORMANT John Dillon		Address Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney				DATE SIGNED 12-22-56			
EXAMINER'S NAME (Type) John T. Maloney MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/23/56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Yeadon, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR Dec 24, 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

John T. Malone, Jr.

CERTIFICATE OF DEATH

12769

Reg. Dist. No.

130

1. PLACE OF DEATH a. COUNTY <i>Pr. Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>va</i> b. COUNTY <i>Culpeper</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>COLLEGE PARK</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CULPEPER</i>	
c. LENGTH OF STAY IN 1b <i>2 dy 5</i>		d. STREET ADDRESS <i>5215-IROQUOIS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5215-IROQUOIS</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>BENJAMIN LEE Dodson</i>		4. DATE OF DEATH <i>DEC 7 1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MONTH UNKNOWN 1869</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMING</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>VA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Lewis Dodson</i>		14. MOTHER'S MAIDEN NAME <i>JANE JENKINS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give way or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>CHAS Dodson</i>		Address <i>3608 Metzerott Rd COLLEGE PARK</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussive heart failure</i> <i>420.0</i> DUE TO <i>Arterio-sclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma colon & abdominal metastasis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <i>56</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>12-7</i> , 19 <i>56</i> , to <i>12-7-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12-7-56</i> , 19 <i>56</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>College Park, Md.</i> DATE SIGNED <i>12-7-56</i>			
ACTUAL SIGNATURE <i>W. L. Etienne</i> M.D. <i>—</i>			
PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/10/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Salem Baptist Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Culpeper County Virginia.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>DEL 10 1956</i>		24b. REGISTRAR'S SIGNATURE <i>John A. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12836

CERTIFICATE OF DEATH

12770

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEWISDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEWISDALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2105 LEWISDALE DRIVE</u>				d. STREET ADDRESS <u>2105 LEWISDALE DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH DUMFORD</u>				4. DATE OF DEATH Month Day Year <u>Dec 13 1956 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Usilton</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. BIDDLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>CLARENCE L. DUMFORD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE + UREMIA</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>1 yr (?)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIO SCLEROSIS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JUNE 4</u> , 19 <u>55</u> to <u>DEC 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>56</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u>				ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY LANE</u>			
DATE SIGNED <u>12/13/56</u>							
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				<u>HYATTSVILLE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-17-56</u>		<u>FORT LINCOLN</u>		<u>CILGAR MANOR MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons</u>				ADDRESS <u>300-4 ST NE</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 16 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John F. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 19 1956</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
10. SIGNATURE OF REGISTRAR <i>John F. Smith</i>		11. SIGNATURE OF WITNESSES <i>John F. Smith</i>		12. SIGNATURE OF DECEASED <i>John F. Smith</i>	
13. SIGNATURE OF DECEASED <i>John F. Smith</i>		14. SIGNATURE OF DECEASED <i>John F. Smith</i>		15. SIGNATURE OF DECEASED <i>John F. Smith</i>	
16. SIGNATURE OF DECEASED <i>John F. Smith</i>		17. SIGNATURE OF DECEASED <i>John F. Smith</i>		18. SIGNATURE OF DECEASED <i>John F. Smith</i>	
19. SIGNATURE OF DECEASED <i>John F. Smith</i>		20. SIGNATURE OF DECEASED <i>John F. Smith</i>		21. SIGNATURE OF DECEASED <i>John F. Smith</i>	
22. SIGNATURE OF DECEASED <i>John F. Smith</i>		23. SIGNATURE OF DECEASED <i>John F. Smith</i>		24. SIGNATURE OF DECEASED <i>John F. Smith</i>	
25. SIGNATURE OF DECEASED <i>John F. Smith</i>		26. SIGNATURE OF DECEASED <i>John F. Smith</i>		27. SIGNATURE OF DECEASED <i>John F. Smith</i>	
28. SIGNATURE OF DECEASED <i>John F. Smith</i>		29. SIGNATURE OF DECEASED <i>John F. Smith</i>		30. SIGNATURE OF DECEASED <i>John F. Smith</i>	
31. SIGNATURE OF DECEASED <i>John F. Smith</i>		32. SIGNATURE OF DECEASED <i>John F. Smith</i>		33. SIGNATURE OF DECEASED <i>John F. Smith</i>	
34. SIGNATURE OF DECEASED <i>John F. Smith</i>		35. SIGNATURE OF DECEASED <i>John F. Smith</i>		36. SIGNATURE OF DECEASED <i>John F. Smith</i>	
37. SIGNATURE OF DECEASED <i>John F. Smith</i>		38. SIGNATURE OF DECEASED <i>John F. Smith</i>		39. SIGNATURE OF DECEASED <i>John F. Smith</i>	
40. SIGNATURE OF DECEASED <i>John F. Smith</i>		41. SIGNATURE OF DECEASED <i>John F. Smith</i>		42. SIGNATURE OF DECEASED <i>John F. Smith</i>	
43. SIGNATURE OF DECEASED <i>John F. Smith</i>		44. SIGNATURE OF DECEASED <i>John F. Smith</i>		45. SIGNATURE OF DECEASED <i>John F. Smith</i>	
46. SIGNATURE OF DECEASED <i>John F. Smith</i>		47. SIGNATURE OF DECEASED <i>John F. Smith</i>		48. SIGNATURE OF DECEASED <i>John F. Smith</i>	
49. SIGNATURE OF DECEASED <i>John F. Smith</i>		50. SIGNATURE OF DECEASED <i>John F. Smith</i>		51. SIGNATURE OF DECEASED <i>John F. Smith</i>	
52. SIGNATURE OF DECEASED <i>John F. Smith</i>		53. SIGNATURE OF DECEASED <i>John F. Smith</i>		54. SIGNATURE OF DECEASED <i>John F. Smith</i>	
55. SIGNATURE OF DECEASED <i>John F. Smith</i>		56. SIGNATURE OF DECEASED <i>John F. Smith</i>		57. SIGNATURE OF DECEASED <i>John F. Smith</i>	
58. SIGNATURE OF DECEASED <i>John F. Smith</i>		59. SIGNATURE OF DECEASED <i>John F. Smith</i>		60. SIGNATURE OF DECEASED <i>John F. Smith</i>	
61. SIGNATURE OF DECEASED <i>John F. Smith</i>		62. SIGNATURE OF DECEASED <i>John F. Smith</i>		63. SIGNATURE OF DECEASED <i>John F. Smith</i>	
64. SIGNATURE OF DECEASED <i>John F. Smith</i>		65. SIGNATURE OF DECEASED <i>John F. Smith</i>		66. SIGNATURE OF DECEASED <i>John F. Smith</i>	
67. SIGNATURE OF DECEASED <i>John F. Smith</i>		68. SIGNATURE OF DECEASED <i>John F. Smith</i>		69. SIGNATURE OF DECEASED <i>John F. Smith</i>	
70. SIGNATURE OF DECEASED <i>John F. Smith</i>		71. SIGNATURE OF DECEASED <i>John F. Smith</i>		72. SIGNATURE OF DECEASED <i>John F. Smith</i>	
73. SIGNATURE OF DECEASED <i>John F. Smith</i>		74. SIGNATURE OF DECEASED <i>John F. Smith</i>		75. SIGNATURE OF DECEASED <i>John F. Smith</i>	
76. SIGNATURE OF DECEASED <i>John F. Smith</i>		77. SIGNATURE OF DECEASED <i>John F. Smith</i>		78. SIGNATURE OF DECEASED <i>John F. Smith</i>	
79. SIGNATURE OF DECEASED <i>John F. Smith</i>		80. SIGNATURE OF DECEASED <i>John F. Smith</i>		81. SIGNATURE OF DECEASED <i>John F. Smith</i>	
82. SIGNATURE OF DECEASED <i>John F. Smith</i>		83. SIGNATURE OF DECEASED <i>John F. Smith</i>		84. SIGNATURE OF DECEASED <i>John F. Smith</i>	
85. SIGNATURE OF DECEASED <i>John F. Smith</i>		86. SIGNATURE OF DECEASED <i>John F. Smith</i>		87. SIGNATURE OF DECEASED <i>John F. Smith</i>	
88. SIGNATURE OF DECEASED <i>John F. Smith</i>		89. SIGNATURE OF DECEASED <i>John F. Smith</i>		90. SIGNATURE OF DECEASED <i>John F. Smith</i>	
91. SIGNATURE OF DECEASED <i>John F. Smith</i>		92. SIGNATURE OF DECEASED <i>John F. Smith</i>		93. SIGNATURE OF DECEASED <i>John F. Smith</i>	
94. SIGNATURE OF DECEASED <i>John F. Smith</i>		95. SIGNATURE OF DECEASED <i>John F. Smith</i>		96. SIGNATURE OF DECEASED <i>John F. Smith</i>	
97. SIGNATURE OF DECEASED <i>John F. Smith</i>		98. SIGNATURE OF DECEASED <i>John F. Smith</i>		99. SIGNATURE OF DECEASED <i>John F. Smith</i>	
100. SIGNATURE OF DECEASED <i>John F. Smith</i>		101. SIGNATURE OF DECEASED <i>John F. Smith</i>		102. SIGNATURE OF DECEASED <i>John F. Smith</i>	

RECEIVED
JEC 19 1956
BUREAU V. 3

CERTIFICATE OF DEATH

12771

Reg. Dist. No.

12781

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Dyce</u> Last <u>Dyce</u>				4. DATE OF DEATH Month <u>12-</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-79</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>228-05-5191</u>			
17. INFORMANT <u>Brentwood, Md.</u> Address <u>Mrs. Sophia Dyce 3918 Allinson St.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>5 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>56</u> , to <u>12/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>56</u> , and that death occurred at <u>4:30 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John K. Ehr</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery Washington D.C.</u>		22d. LOCATION (City, town, or county) <u>(S)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Mc</u>				ADDRESS <u>1820 9th St Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Seach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 12 1956

REF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Easter Last				4. DATE OF DEATH Month December Day 9 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1929	
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mamie Easter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 228280534		17. INFORMANT Gracie Dugger; Edgerton, Va. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Multiple fractures and lacerations Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Automobile accident DUE TO (c) Automobile accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an auto. which went off the road crashing a guard rail.			
20c. TIME OF INJURY Month, Day, Year 8.15 a.m. 12-9-56 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Laurel, AnneArundel, Md.				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-9-56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORY Union Bethel Cemetery, Edgerton		22d. LOCATION (City, town, or county) Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gracie Sma Hyattsville ADDRESS				24a. REC'D BY REGISTRAR DEC 13 '56 DATE		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 245

12783

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days 10 hrs. Cheverly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Louise Eberly				4. DATE OF DEATH Month Day Year 12- 9 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/90	
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.S. Operator		10b. KIND OF BUSINESS OR INDUSTRY Apartment		11. BIRTHPLACE (State of foreign country) Gallipolis, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Dick Stowers				14. MOTHER'S MAIDEN NAME Mary Harriett Curry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579-48-5383		17. INFORMANT Catherine E. Brown Address 3500-56th Pl. Chevy Chase Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 acute pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right adrenal hemorrhage INTERVAL BETWEEN ONSET AND DEATH 6 hrs 6 hrs							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/12 to 12/19, 1956, that I last saw the deceased alive on 12/19/56, 1956, and that death occurred at 8:50 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John Kehoe M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc. Md.				24a. REC'D BY REGISTRAR DATE 12-11-1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G208 12-19-56 et

CERTIFICATE OF DEATH

12774

Reg. Dist. No.

12837

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Park - Seat Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7249 Booker Drive (home)</u>		d. STREET ADDRESS <u>7249-Booker Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Elliot</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Fayetteville, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Mary -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Estelle Frye (daughter)</u>		Address <u>4913 Wash Pl. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Nephrosclerosis</u> DUE TO (c) <u>Essential Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 15, 1956</u> , to <u>Dec 8, 1956</u> , that I last saw the deceased alive on <u>Dec 8, 1956</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4649-Dean Ave. N.E.</u> DATE SIGNED <u>12/8/56</u>			
ACTUAL SIGNATURE <u>Wilbur F. Jackson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wilbur F. Jackson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u></u>	<u>12-13-56</u>	<u>Lincoln Memorial</u>	<u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mystle R. Rollins</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

DEC 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12775

Reg. Dist. No.

12784

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 517 74th Street, N.E.			
3. NAME OF DECEASED (Type or print) First Leo Middle Aloysius Last Ermer				4. DATE OF DEATH Month December Day 5 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1998		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Fireman		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Ermer				14. MOTHER'S MAIDEN NAME Minnie Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 270-07-0769		17. INFORMANT Address Ida Ackerman; 406 71st Street, Seat Pleasant, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 442 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 5, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cam.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR DEC 11 1956		24b. REGISTRAR'S SIGNATURE Attest	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible]

DECEASED: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

ADDRESS: [illegible]

DATE: [illegible]

CAUSE OF DEATH: [illegible]

BUREAU V. A.

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12776

12838

CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 6 mo., 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. STREET ADDRESS 210 - F. St., N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Russel Middle Lee Last Estelle				4. DATE OF DEATH Month 12 Day 15 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/24/13	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Herbert Estelle				14. MOTHER'S MAIDEN NAME Julia Stanton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) 1942-1945		16. SOCIAL SECURITY NO. 217-20-4288		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cor pulmonale, 1 year				INTERVAL BETWEEN ONSET AND DEATH 3 yrs., 3 mo's			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/25, 1956 , to 12/15, 1956 , that I last saw the deceased alive on 12/15/56 , 19, and that death occurred at 4:50 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Glenn Dale, Maryland				DATE SIGNED 12/15/56			
ACTUAL SIGNATURE Daniel Leo Finucane M.D.							
PHYSICIAN'S NAME (Type) Daniel Leo Finucane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/56		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Pt. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co				ADDRESS 1400 Chapin St NW		24a. REC'D BY REGISTRAR DATE 12/15/56	
				24b. REGISTRAR'S SIGNATURE W. W. Chambers			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MOTHER'S MARRIAGE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		DRIVER		DRIVER		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
DEC 26 1956		MEMPHIS		SHOOTING		SUICIDE		YES		YES		YES		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY		STATE	
DEC 26 1956		10:00 PM		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	

BUREAU V. 3

DEC 26 1956

RECEIVED

12785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	c. LENGTH OF STAY IN 1b <u>7 1/4 Hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>4912 Branchville Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Feighenne</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-72</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Section Railroad Foreman</u>	11. BIRTHPLACE (State or foreign country) <u>Beltsville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Jacob Feighenne</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Benson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Isabel Anderson</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-27</u> , 19 <u>56</u> , to <u>12-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>56</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D. <u>4712-12-29-56</u>		ADDRESS (Street, city or town, state) <u>College Park, Md.</u> DATE SIGNED <u>12-29-56</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ammendale Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 3 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10725

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. PLACE OF DEATH [REDACTED]	
11. SIGNATURE OF PHYSICIAN [REDACTED]		12. SIGNATURE OF REGISTRAR [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]	
15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF SECOND WITNESS [REDACTED]	
17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF NEXT OF KIN [REDACTED]	
19. SIGNATURE OF CLERK [REDACTED]		20. SIGNATURE OF CHIEF CLERK [REDACTED]	
21. SIGNATURE OF ASSISTANT CLERK [REDACTED]		22. SIGNATURE OF DEPUTY CLERK [REDACTED]	
23. SIGNATURE OF DEPUTY CLERK [REDACTED]		24. SIGNATURE OF DEPUTY CLERK [REDACTED]	
25. SIGNATURE OF DEPUTY CLERK [REDACTED]		26. SIGNATURE OF DEPUTY CLERK [REDACTED]	
27. SIGNATURE OF DEPUTY CLERK [REDACTED]		28. SIGNATURE OF DEPUTY CLERK [REDACTED]	
29. SIGNATURE OF DEPUTY CLERK [REDACTED]		30. SIGNATURE OF DEPUTY CLERK [REDACTED]	
31. SIGNATURE OF DEPUTY CLERK [REDACTED]		32. SIGNATURE OF DEPUTY CLERK [REDACTED]	
33. SIGNATURE OF DEPUTY CLERK [REDACTED]		34. SIGNATURE OF DEPUTY CLERK [REDACTED]	
35. SIGNATURE OF DEPUTY CLERK [REDACTED]		36. SIGNATURE OF DEPUTY CLERK [REDACTED]	
37. SIGNATURE OF DEPUTY CLERK [REDACTED]		38. SIGNATURE OF DEPUTY CLERK [REDACTED]	
39. SIGNATURE OF DEPUTY CLERK [REDACTED]		40. SIGNATURE OF DEPUTY CLERK [REDACTED]	
41. SIGNATURE OF DEPUTY CLERK [REDACTED]		42. SIGNATURE OF DEPUTY CLERK [REDACTED]	
43. SIGNATURE OF DEPUTY CLERK [REDACTED]		44. SIGNATURE OF DEPUTY CLERK [REDACTED]	
45. SIGNATURE OF DEPUTY CLERK [REDACTED]		46. SIGNATURE OF DEPUTY CLERK [REDACTED]	
47. SIGNATURE OF DEPUTY CLERK [REDACTED]		48. SIGNATURE OF DEPUTY CLERK [REDACTED]	
49. SIGNATURE OF DEPUTY CLERK [REDACTED]		50. SIGNATURE OF DEPUTY CLERK [REDACTED]	
51. SIGNATURE OF DEPUTY CLERK [REDACTED]		52. SIGNATURE OF DEPUTY CLERK [REDACTED]	
53. SIGNATURE OF DEPUTY CLERK [REDACTED]		54. SIGNATURE OF DEPUTY CLERK [REDACTED]	
55. SIGNATURE OF DEPUTY CLERK [REDACTED]		56. SIGNATURE OF DEPUTY CLERK [REDACTED]	
57. SIGNATURE OF DEPUTY CLERK [REDACTED]		58. SIGNATURE OF DEPUTY CLERK [REDACTED]	
59. SIGNATURE OF DEPUTY CLERK [REDACTED]		60. SIGNATURE OF DEPUTY CLERK [REDACTED]	
61. SIGNATURE OF DEPUTY CLERK [REDACTED]		62. SIGNATURE OF DEPUTY CLERK [REDACTED]	
63. SIGNATURE OF DEPUTY CLERK [REDACTED]		64. SIGNATURE OF DEPUTY CLERK [REDACTED]	
65. SIGNATURE OF DEPUTY CLERK [REDACTED]		66. SIGNATURE OF DEPUTY CLERK [REDACTED]	
67. SIGNATURE OF DEPUTY CLERK [REDACTED]		68. SIGNATURE OF DEPUTY CLERK [REDACTED]	
69. SIGNATURE OF DEPUTY CLERK [REDACTED]		70. SIGNATURE OF DEPUTY CLERK [REDACTED]	
71. SIGNATURE OF DEPUTY CLERK [REDACTED]		72. SIGNATURE OF DEPUTY CLERK [REDACTED]	
73. SIGNATURE OF DEPUTY CLERK [REDACTED]		74. SIGNATURE OF DEPUTY CLERK [REDACTED]	
75. SIGNATURE OF DEPUTY CLERK [REDACTED]		76. SIGNATURE OF DEPUTY CLERK [REDACTED]	
77. SIGNATURE OF DEPUTY CLERK [REDACTED]		78. SIGNATURE OF DEPUTY CLERK [REDACTED]	
79. SIGNATURE OF DEPUTY CLERK [REDACTED]		80. SIGNATURE OF DEPUTY CLERK [REDACTED]	
81. SIGNATURE OF DEPUTY CLERK [REDACTED]		82. SIGNATURE OF DEPUTY CLERK [REDACTED]	
83. SIGNATURE OF DEPUTY CLERK [REDACTED]		84. SIGNATURE OF DEPUTY CLERK [REDACTED]	
85. SIGNATURE OF DEPUTY CLERK [REDACTED]		86. SIGNATURE OF DEPUTY CLERK [REDACTED]	
87. SIGNATURE OF DEPUTY CLERK [REDACTED]		88. SIGNATURE OF DEPUTY CLERK [REDACTED]	
89. SIGNATURE OF DEPUTY CLERK [REDACTED]		90. SIGNATURE OF DEPUTY CLERK [REDACTED]	
91. SIGNATURE OF DEPUTY CLERK [REDACTED]		92. SIGNATURE OF DEPUTY CLERK [REDACTED]	
93. SIGNATURE OF DEPUTY CLERK [REDACTED]		94. SIGNATURE OF DEPUTY CLERK [REDACTED]	
95. SIGNATURE OF DEPUTY CLERK [REDACTED]		96. SIGNATURE OF DEPUTY CLERK [REDACTED]	
97. SIGNATURE OF DEPUTY CLERK [REDACTED]		98. SIGNATURE OF DEPUTY CLERK [REDACTED]	
99. SIGNATURE OF DEPUTY CLERK [REDACTED]		100. SIGNATURE OF DEPUTY CLERK [REDACTED]	

RECEIVED
JAN 3 1957
BUREAU V. 5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

127779
Reg. Dist. No.

12839

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 761		d. STREET ADDRESS Route # 1 Box 273A	
3. NAME OF DECEASED (Type or print) First Richard Middle Benjamin Last Ford		4. DATE OF DEATH Month December Day 5 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1932
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gasolene	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Ford		14. MOTHER'S MAIDEN NAME Edna M. Colbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 50-53	
17. INFORMANT Edna M. Colbert		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the skull, fracture of the mandible (c) Fracture of the left tibia near the knee and the right femur crushed chest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) a tree	
20c. TIME OF INJURY Month, Day, Year Hour 1:35 p. m. 12/5 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Road	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Upper Marlboro PG Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED December 5, 1956	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL (CREMATION, REMOVAL) (Specify) Burial		22b. DATE THEREOF 12/11/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. G. Gooch		24a. REC'D BY REGISTRAR DEC 12 56	
24b. REGISTRAR'S SIGNATURE W. J. Smith			

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS' CERTIFICATE OF DEATH

1956

Route 1 Box 272A

Penitentiary

August 13, 1956

101-10

also

See station report on telephone

Marquette

John A. Colbert

John A. Colbert

John A. Colbert same as 2

UNK

Yes

10-10

See station report on telephone

Fracture of the skull, fracture of the mandible
Fracture of the left tibia near the knee and the right tibia
Crushed skull

3 trees

Location of automobile crash on left side and right side

BUREAU V. S.

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12780 47
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights.			c. LENGTH OF STAY IN 1b 48 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 717 60th Place. Municipal Building				d. STREET ADDRESS 5909 K. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Francis				4. DATE OF DEATH Month December Day 7, Year 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired assistant		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Henry Francis, Sr.				14. MOTHER'S MAIDEN NAME Mary Hamilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Address Mary Jane Francis; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL: CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 12/13/56		22c. NAME OF CEMETERY OR CREMATORY mt olivet	
22d. LOCATION (City, town, or county) (State)				22e. (City or town) (County) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros. 621 Fla ave.				24a. REC'D BY REGISTRAR DEC 17 1956		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

John T. Maoney, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

December 7, 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Henry French, Sr.	
Sex		Male	
Age		68 years	
Date of Death		December 17, 1956	
Place of Death		1700 N. E. Street, Baltimore, Md.	
Cause of Death		Coronary artery disease; atherosclerosis	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	

BUREAU V. 2

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12781

12841

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
c. LENGTH OF STAY IN b 10 Month		d. STREET ADDRESS 7207-7 St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 7207-7 St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle L. Last GATES		4. DATE OF DEATH Month 12 - Day 29 Year 1956	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1876	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Hays		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral Vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIO-VASCULAR DISEASE (c) ARTERIO-SCLERIOSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 8 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12/28, 1956, to 12/29, 1956, that I last saw the deceased alive on 12/28, 1956, and that death occurred at 5 A. M. from the causes and on the date stated above.		
ACTUAL SIGNATURE Max M. Herzberg M.D.		ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type) MAX M. HERZBERG, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1-2-57	22c. NAME OF CEMETERY OR CREMATORY Congressional
22d. LOCATION (City, town, or county) Washington D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE W. M. Chambers		24a. REC'D BY REGISTRAR DATE 1-2-57
24b. REGISTRAR'S SIGNATURE Carrie J. Campbell		

BUREAU V. S.

1957 7 N

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12782

12751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4209 Eastern Avenue				d. STREET ADDRESS 4209 Eastern Ave			
3. NAME OF DECEASED (Type or print) Elizabeth E. Siddens				4. DATE OF DEATH Dec 29 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-1871	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Wash D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hatcher				14. MOTHER'S MAIDEN NAME Elizabeth Everett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George W. Siddens Address 4209 Eastern Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Chronic Appendicitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 years.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1951, to Dec. 29, 1956, that I last saw the deceased alive on Dec 29, 1956, and that death occurred at 12:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.S. Williams				ADDRESS (Street, city or town, state) 35 New York Ave NW Wash D.C. DATE SIGNED 12-29-56			
PHYSICIAN'S NAME (Type) R.S. WILLIAMS, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Wash D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly				ADDRESS 131-11 St Wash D.C.		24a. REC'D BY REGISTRAR DATE 12-29-56	
				24b. REGISTRAR'S SIGNATURE James C. Brown			

BUREAU V. S.

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Heights</u> c. LENGTH OF STAY IN 1b <u>1 month</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Heights</u> d. STREET ADDRESS <u>2303 Houston Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
---	--	--	--

3. NAME OF DECEASED (Type or print) First <u>CAROL</u> Middle <u>LEE</u> Last <u>GOLDSMITH</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8th</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25, 1951</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None--Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
---	---	---

12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Ballenger Goldsmith</u>
---	--

14. MOTHER'S MAIDEN NAME <u>Norma McIntosh</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>
--	--	---

17. INFORMANT <u>Ballenger Goldsmith, 2303 Houston Road</u>		Address <u>Bradbury Hts., Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>344x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>John T. Maloney</u> EXAMINER'S NAME (Type) <u>John T. Maloney</u>	DATE SIGNED <u>DEC/8/1956</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
--	---

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., 517--11th St. S.E. Wash. DC</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>DEC 12 1956</u> <u>A. H. Hedrick</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED
DEC 12 1956
BUREAU V. 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

12843

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkeshire		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkeshire		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7316 Hanford St				d. STREET ADDRESS 7316-Hanford St			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Edward Grant				4. DATE OF DEATH Month Day Year Dec 2 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1879	
9. AGE (in years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTH PLACE (State or foreign country) District of Columbia U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James L. Grant				14. MOTHER'S MAIDEN NAME Rebecca Short			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Estelle M. Grant, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X Cerebrovascular accident DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-5-56		22c. NAME OF CEMETERY OR CREMATORY Washington Nat.	
22d. LOCATION (City, town, or county) State) Suitland Md				23. FUNERAL DIRECTOR'S SIGNATURE J. W. Zero Bone Wash. D. C.		24a. REC'D BY REGISTRAR DATE 12-3-56	
24b. REGISTRAR'S SIGNATURE Carrie Campbell				DATE SIGNED Dec 2, 1956			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31
DEC 4 1956

RECEIVED

12844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u>				c. LENGTH OF STAY IN 1b <u>3 dss</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON.</u>				4723			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>511 68th ST.</u>				d. STREET ADDRESS <u>1728 L ST N.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>HENRY M. GRAY</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 28, 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOB</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH TERMINAL</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>							
13. FATHER'S NAME <u>JOSEPH GRAY</u>				14. MOTHER'S MAIDEN NAME <u>DARRAS ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOSEPH B. GRAY</u> Address <u>511 68th St SEAT PLEASANT, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>3 MOS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 24, 1956</u> , to <u>DEC. 25, 1956</u> , that I last saw the deceased alive on <u>DEC. 24, 1956</u> , and that death occurred <u>ALL 05 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John O. Ford</u> M.D. <u>7200 MARLBORO RD.</u>				<u>12-25-56</u>			
PHYSICIAN'S NAME (Type) <u>JOHN O. FORD</u>				<u>DISTRICT HEIGHTS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-28-56</u>		<u>Fort Lincoln Cemetery</u>		<u>Bladensburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES GEORGE		DATE OF DEATH DEC 28 1956	
AGE 68		SEX M	
MARRIAGE MARRIED		OCCUPATION FARMER	
PLACE OF BIRTH BALTIMORE, MD.		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF BURIAL DEC 29 1956		PLACE OF BURIAL BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN J. H. [illegible]		SIGNATURE OF MINISTER [illegible]	
SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]	
DATE OF CERTIFICATE DEC 28 1956		PLACE OF CERTIFICATE BALTIMORE, MD.	

RECEIVED
DEC 28 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 209 1-4-57 et

12845

CERTIFICATE OF DEATH

12786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landon Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landon Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>				d. STREET ADDRESS <u>7111 Buchanan St.</u>			
3. NAME OF DECEASED (Type or print) <u>Louisa</u> First <u>Clare</u> Middle <u>Gregory</u> Last <u>Gregory</u>				4. DATE OF DEATH <u>Dec 21</u> Month <u>21</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 26 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash DC</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Evans</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Leahy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7111 Buchanan St</u>		17. INFORMANT <u>Alfred Gregory</u> Address <u>Landon Hill Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-arterio-sclerosis</u> (c) <u>Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>56</u> , to <u>Dec 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Chester Brady</u>				DATE SIGNED <u>Dec 25 1956</u>			
PHYSICIAN'S NAME (Type) <u>J. Chester Brady</u>				ADDRESS <u>35 N.Y. Avenue N.W. Wash, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Mattingly</u>				ADDRESS <u>131-110 St</u>		24a. REC'D BY REGISTRAR <u>DEC 26 56</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Gregory</u>							

CERTIFICATE OF DEATH

Form 1-1-54

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Race: *White*

4. Date of Birth: *1910-01-01*

5. Date of Death: *1956-12-27*

6. Place of Birth: *Washington, D.C.*

7. Usual Residence: *123 Main St, Baltimore, Md.*

8. Cause of Death: *Heart Disease*

9. Manner of Death: *Natural*

10. Signature of Physician: *[Signature]*

11. Signature of Registrar: *[Signature]*

12. Date of Registration: *1956-12-28*

13. County: *Baltimore*

14. City: *Baltimore*

15. State: *Md.*

16. District: *1*

17. Block: *1*

18. Lot: *1*

19. Sublot: *1*

20. Tract: *1*

21. Section: *1*

22. Township: *1*

23. Range: *1*

24. Meridian: *1*

25. Township: *1*

26. Range: *1*

27. Meridian: *1*

28. Township: *1*

29. Range: *1*

30. Meridian: *1*

BUREAU V. S.

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12786

CERTIFICATE OF DEATH

13113

Reg. Dist. No.

239

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sandy Spring Road</u>		d. STREET ADDRESS <u>Sandy Spring Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Elizabeth Gurnell</u>		4. DATE OF DEATH Month Day Year <u>December 31 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20 1858</u> 78 yrs.
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Petty</u>		14. MOTHER'S MAIDEN NAME <u>Ann Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT Address <u>Mrs. Maud Thomas Laurel Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vasc.</u> 20 yr. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio Sclerosis</u> 30 yr. DUE TO (c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/26</u> , 19 <u>56</u> , to <u>12/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/27/56</u> , 19 <u>56</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Laurel</u> <u>1/2/57</u>			
ACTUAL SIGNATURE <u>J. M. Warren</u>		M.D. <u>Laurel</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 3 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Episcopal Cemetery, Howard Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Kowalsky</u>		24a. REC'D BY REGISTRAR <u>Laurel</u>	24b. REGISTRAR'S SIGNATURE <u>M. Kraschinsky</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MUSTARD		MALE		35		JAN 14 1927		MONTANA	
MARRIAGE		MARRIED		10		JAN 14 1927		MONTANA	
EDUCATION		HIGH SCHOOL		10		JAN 14 1927		MONTANA	
OCCUPATION		FARMER		10		JAN 14 1927		MONTANA	
CAUSE OF DEATH		HEART DISEASE		10		JAN 14 1927		MONTANA	
MANNER OF DEATH		NATURAL		10		JAN 14 1927		MONTANA	
PLACE OF DEATH		HOME		10		JAN 14 1927		MONTANA	
DATE OF DEATH		JAN 14 1927		10		JAN 14 1927		MONTANA	
TIME OF DEATH		10:00 AM		10		JAN 14 1927		MONTANA	
SIGNATURE OF DECEASED		MUSTARD		10		JAN 14 1927		MONTANA	
SIGNATURE OF WITNESS		MUSTARD		10		JAN 14 1927		MONTANA	
SIGNATURE OF PHYSICIAN		MUSTARD		10		JAN 14 1927		MONTANA	
SIGNATURE OF CLERK		MUSTARD		10		JAN 14 1927		MONTANA	

RECEIVED
JAN 14 1927
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12787

Reg. Dist. No. 202

12845

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6230 Addison Rd SE				e. STREET ADDRESS 6230 Addison Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Anna Gunther				4. DATE OF DEATH Month Day Year Dec 23 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Gm (Home)		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.E.							
13. FATHER'S NAME Frederick Klickerman				14. MOTHER'S MAIDEN NAME Anna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Paul Gunther Address same as #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X Uremia DUE TO (b) Glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-56		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington D.C.				24a. REC'D BY REGISTRAR DATE 7/31/56		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BUREAU V. S.

DEC 31 1956

RECEIVED

12847

CERTIFICATE OF DEATH

12788

Reg. Dist. No. 240

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>				c. LENGTH OF STAY IN 1b <u>Transient</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Main Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>A.</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farms</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Clarence Hall</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bowling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Frank Hall</u>	
Address <u>Upper Marlboro, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> DUE TO <u>3 days</u> (c) <u>Arteriosclerosis</u> DUE TO <u>Unk</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>24 Dec</u> , 19 <u>56</u> , to <u>26 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>24 Dec</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Upper Marlboro, Maryland</u> DATE SIGNED <u>12/26/56</u>							
ACTUAL SIGNATURE <u>Robert B. Sasscer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Robert B. Sasscer</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u> ADDRESS <u>Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 31 56</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. EDUCATION		10. RELIGION		11. SOCIAL CLASS		12. CAUSE OF DEATH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. MANNER OF DEATH		17. MEDICAL HISTORY		18. HISTORY OF PRESENT ILLNESS	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF CORONER		24. SIGNATURE OF JUDGE	

RECEIVED
DEC 31 1956
BUREAU V. S.

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death.
2. The cause of death should be stated in as much detail as possible, and should include the immediate cause, the underlying cause, and any other significant conditions.
3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.
4. The medical history should be stated in as much detail as possible, and should include all significant conditions, including chronic diseases, recent illnesses, and all medications taken.
5. The history of present illness should be stated in as much detail as possible, and should include all symptoms, signs, and diagnostic tests.
6. The signature of the physician or other qualified person should be written in ink, and should be accompanied by a printed name and title.
7. The signature of the witnesses should be written in ink, and should be accompanied by a printed name and address.
8. The signature of the deceased should be written in ink, and should be accompanied by a printed name and address.
9. The signature of the funeral home should be written in ink, and should be accompanied by a printed name and address.
10. The signature of the coroner should be written in ink, and should be accompanied by a printed name and address.
11. The signature of the judge should be written in ink, and should be accompanied by a printed name and address.
12. This certificate is to be filed in the office of the State Department of Health, and a copy is to be sent to the local health department.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12754 CERTIFICATE OF DEATH

12789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thelma Bellis Nursing Home 6303 Ager Rd.		d. STREET ADDRESS 1002 Quebec Terrace	
3. NAME OF DECEASED (Type or print) First KAREN Middle JEAN Last HANNAWAY		4. DATE OF DEATH Month December Day 21 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10-1956
9. AGE (In years last birthday) yrs. 2 Months 11 Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George K. Hannaway	
14. MOTHER'S MAIDEN NAME Verity Ingram		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. None		17. INFORMANT Father, Geo. K. Hannaway, Silver Sp. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 753.1 DUE TO Congenital brain anomaly - type undetermined (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH about 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic like seizures		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10, 1956, to 12/21, 1956, that I last saw the deceased alive on 12/19, 1956, and that death occurred at 7:15 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert D. Glick		ADDRESS (Street, city or town, state) 8301 Piney Branch Rd., Silver Spring, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Herbert D. Glick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md	
24a. REC'D BY REGISTRAR DATE 26 1956		24b. REGISTRAR'S SIGNATURE James E. Leaven	

2075222XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES M. WATSON		JAN 10 1956		BALTIMORE, MD	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		CITY OF RESIDENCE	
JAN 10 1891		BALTIMORE, MD		BALTIMORE, MD	
OCCUPATION		EDUCATION		MARRIAGE	
RETIRED		HIGH SCHOOL		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HEART DISEASE		NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
J. M. WATSON		J. M. WATSON		JAN 10 1956	

RECEIVED
DEC 26 1956
BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12790

12848

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Road		e. STREET ADDRESS 2045 AACS Group	
3. NAME OF DECEASED (Type or print) First Allen Middle Bernard Last Hardy		4. DATE OF DEATH Month December Day 22 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1934
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 22 Days 22 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Airforce		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Huron, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hardy		14. MOTHER'S MAIDEN NAME Loretta	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Present		16. SOCIAL SECURITY NO. 270-28974	
17. INFORMANT U.S. Army Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of base of the skull (c) Fracture and dislocation of 2-4 cervical PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2-4 cervical		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an auto	
20c. TIME OF INJURY Month, Day, Year 2-22-56 Hour 12-22 o. m. 12-22 p. m. 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) Morningside P.G. Md (County) Prince George's (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I Boyd		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec 27, 1956	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-56	
22c. NAME OF CEMETERY OR CREMATORY Huron Ohio		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M.W. Chambers to 517-11 St. A.E.		ADDRESS	
24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE D.W. Leland	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
DEC 27 1956
BUREAU V. S.

Name of Deceased		John Doe	
Sex		Male	
Race		White	
Date of Birth		January 1, 1900	
Place of Birth		Baltimore, Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Death		December 20, 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12791

12787

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>14</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4000 52nd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Esther Harris</u>				4. DATE OF DEATH Month Day Year <u>December 30 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-13-19</u>		9. AGE (In years last birthday) yrs. <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ed ward J. O' Neil</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>012 166 312</u>		17. INFORMANT <u>George Harris</u> Address <u>Bladensburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-17, 1956</u> , to <u>12-30, 1956</u> , that I last saw the deceased alive on <u>12-30, 1956</u> , and that death occurred at <u>11:15</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1726 E. St. N.W.</u> DATE SIGNED <u>Wash., D.C.</u>							
ACTUAL SIGNATURE <u>Saul Schwartzbach</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Saul Schwartzbach</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 4 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

234

12849

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5640--Livingston Rd., SE		d. STREET ADDRESS 5640--Livingston Rd., SE	
3. NAME OF DECEASED (Type or print) First Middle Last CHESTER A. HASH		4. DATE OF DEATH Month Day Year Dec. 5th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5-1900
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Repair		10b. KIND OF BUSINESS OR INDUSTRY Griffith Consumers	
11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D Hash		14. MOTHER'S MAIDEN NAME Mary Paris	
15. WAS DECEASED IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Fonzy R. Hash		Address 5640- Livingston Road S. E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia (c) Bronchogenic Carcinoma of lungs.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954, 19, to Dec. 5, 1956, that I last saw the deceased alive on Dec. 4, 1956, and that death occurred at 4:14 PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Dr. Etienne Gallon		M.D. 2 Parkway Dr. - Forest Hgts. (H.D.) 12/5/56	
PHYSICIAN'S NAME (Type) Dr. Szallosi			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7-56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
1661- Good Hope Rd. SE Washington, D. C.		DEC 6 1956 Carrie Campbell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 6 1956

RECEIVED

CERTIFICATE OF DEATH

12788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly				c. LENGTH OF STAY IN 1b 70 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hazel Irene Hasson				4. DATE OF DEATH Month 12 Day 19 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-24-14	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Grover Johnson				14. MOTHER'S MAIDEN NAME Olive Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Claude Hasson, 4707--M--St.Hillside, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 171X Generalized Peritonitis DUE TO Bilateral Hydronephrosis & Uremia DUE TO Carcinoma of the Cervix Uteri Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 months 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/29, 1956 to 12/14, 1956 that I last saw the deceased alive on 12/14, 1956 , and that death occurred at 8:50p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Kennedy Skipton M.D. 722 c Forest Rd., Hyattsville, Md.				DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. Va		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, 517--11th St. S.E. Washington, DC				24a. REGD BY REGISTRAR 12/29		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12789

CERTIFICATE OF DEATH

Reg. Dist. No. 12794

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hosp.				d. STREET ADDRESS 9448 Washington Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Wade Middle Russell Last Hawes				4. DATE OF DEATH Month Dec. 29 Day Year 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-9-14	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair mechanic				10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal		11. BIRTHPLACE (State or foreign country) Va	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wade R Hawes				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 17. INFORMANT Clara N. Hawes Lanham Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Cong + Sclerosis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Failure DUE TO Myocarditis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March, 1956, to 12/29, 1956, that I last saw the deceased alive on 12/29, 1956, and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leon D Gallin M.D. 7206 Coleridge Rd PHYSICIAN'S NAME (Type) Leon Gallin University Hills Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/2/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE JAN 3 '57		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12755 CERTIFICATE OF DEATH

12795

Reg. Dist. No. 240

1. PLACE OF DEATH o. COUNTY <u>Pri Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. E</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4201 Braxton Pl.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Hawkins</u> Last <u>Hawkins</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>P. E.</u>	
13. FATHER'S NAME <u>William Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Lillie Ross</u>		Address <u>Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular Heart disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>High blood pressure</u> DUE TO (c) <u>Senile</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>56</u> , to <u>Dec 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>56</u> , and that death occurred at <u>3 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. S. Hudson</u> M.D. <u>513-8th St</u>		DATE SIGNED <u>Laurel Ind.</u>	
PHYSICIAN'S NAME (Type) <u>W. S. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-2-57</u>		22b. DATE THEREOF <u>Dec 29 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Murkbk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 N. S. E. W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>1/4/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>James Lewis</u>	

BUREAU V. S.

JAN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12796

Item 14, Film G209, 1/1/57 icy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Iceland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John George Heitmuller		4. DATE OF DEATH Month Day Year December 30 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Heitmuller		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Minnie Graham Heitmuller, Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 30, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 2, 1957	
22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON		22d. LOCATION (City, town, or county) (State) PRINCE GEORGES, PRINCE GEORGES CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James Tigger		24a. RECEIVED BY REGISTRAR JAN 2 1957	
24b. REGISTRAR'S SIGNATURE James Tigger		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

• 200 •

Journal of Management Education 30(6)

• • •

1311

Integr. Environ. Assess. Manag.

© 2000

not

042001

252

† TRANSPOSED . 2. 11

750000

...and ...

CONFIDENTIAL

BUREAU V. S.

JAN 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12797

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 1421 Eastern Ave., N.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Arlando Middle Hill Last Hill		4. DATE OF DEATH Month December Day 20 Year 1956	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1924
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 32 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist		10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.	11. BIRTHPLACE (State or foreign country) N. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William P. Hill		14. MOTHER'S MAIDEN NAME Beulah Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Disc'd 1946	
17. INFORMANT William P. Hill, 1437 Eastern Ave., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull DUE TO Automobile accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Automobile accident DUE TO (c) Automobile accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Passenger in an automobile in collision with stopped truck.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with stopped truck.	
20c. TIME OF INJURY Month, Day, Year 6.00 AM 12-20-56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Beltsville, Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 20, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec-26-1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co., 901 3rd St., S. W.		24a. REC'D BY REGISTRAR DEC 27 1956	
		24b. REGISTRAR'S SIGNATURE James L. ...	

MEDICAL CERTIFICATION

25

M 99

I

16

2

MINNAPOLIS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Malone, Jr.	
Sex		Male	
Age		30	
Date of Birth		12-30-1926	
Place of Birth		St. Paul, Minn.	
Occupation		Student	
Cause of Death		Automobile accident	
Manner of Death		Accident	
Place of Death		St. Paul, Minn.	
Date of Death		12-30-1926	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

RECEIVED
DEC 31 1926
BUREAU V. S.

CERTIFICATE OF DEATH

12798

Reg. Dist. No.

12792

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>1-6</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City, MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>3704-40th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u></u> Last <u>Howes</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <u>July 30, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	9. AGE (In years last birthday) <u>64</u> yrs.
13. FATHER'S NAME <u>WILLIAM F. HOWES</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE V. DWYER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding gastric ulcer</u> 540.0 DUE TO <u>linchosis of liver</u> DUE TO <u>Arterio-sclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>12-26-56</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-26</u> , 19 <u>56</u> , to <u>12-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George H. George</u> M.D.		ADDRESS (Street, city or town, state) <u>3717 38th Ave, Cottage City, Md</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE H. GEORGE</u>		DATE SIGNED <u>12-30-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/2/57</u>	<u>Ft. Lincoln</u>	<u>Colmar Manor Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. W. M. Lee Sons Co - Wash, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 3 '57</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1957

RECEIVED

12850

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Beltsville	
c. LENGTH OF STAY IN 1b 5 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle ARTHUR Last HOWES		4. DATE OF DEATH Month Dec , Day 27 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U, S, A,	
13. FATHER'S NAME J ohn Howes		14. MOTHER'S MAIDEN NAME Helen Gaither	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT W ife Grace Howes, Beltsville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Apoplexy, Thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 52 , to Dec , 19 56 , that I last saw the deceased alive on Dec 25 , 19 56 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant		ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring Md. 12/28/56	
PHYSICIAN'S NAME (Type) A. D. Bonifant		Sandy Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec, 29 56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Unity Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR Laytonville Md. 2	
24b. REGISTRAR'S SIGNATURE John D. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Brown		Male		45		Jan 1, 1910		Maryland	
Cause of Death		Disease		Symptoms		Duration		Place of Death	
Heart Disease		Coronary Artery Disease		Chest Pain		2 Weeks		Home	
Occupation		Education		Marital Status		Previous Illnesses		Date of Death	
Farmer		High School		Married		None		Jan 15, 1957	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 2 1957

RECEIVED

Jan 16 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12800

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Carolina</u> b. COUNTY <u>Wilkinson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>	c. LENGTH OF STAY IN 1b <u>Homeless</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkinson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Alentown Road</u>		d. STREET ADDRESS <u>Route #1 Box 202</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gene</u> Middle <u>Carol</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20, 1930</u>
9. AGE (in years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Airforce</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Edwin Earl Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Anne Funderburg</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>3-7-51612-6-54238-36-587</u>		17. INFORMANT <u>U.S. Airforce Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>multiple crushing injuries to the body</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wreck of an automobile that struck a pole</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-36-12-6 1956</u>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Dec 6, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-8-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u> </u>	22d. LOCATION (City, town, or county) (State) <u>Sanford, North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		ADDRESS <u>517-11 St. S.E.</u>	
24a. REC'D BY REGISTRAR <u>DEC 11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

BUREAU A. J.

DEC 11 1956

RECEIVED

CERTIFICATE OF DEATH

12801

Reg. Dist. No.

12793

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 46 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.		d. STREET ADDRESS 5600 36th Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle M. Last Johnson		4. DATE OF DEATH Month Dec. Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-80
9. AGE (In years and months) yrs. 76 yrs.		IF UNDER 1 YEAR Months 12 Days 15 Hours 56 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John McLaughlin	
14. MOTHER'S MAIDEN NAME Mary Devaney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Harry C. Johnson Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 48 hrs 16 days 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH , 1951, to Dec 5 , 1956, that I last saw the deceased alive on Dec 5 , 1956, and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comrau M.D.		ADDRESS (Street, city or town, state) 3503 PENNY ST DATE SIGNED 12/5/56	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMRAU		MT PAINIEN MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Dec 8, 1956	22c. NAME OF CEMETERY OR CREMATORY Rock CREEK	22d. LOCATION (City, town, or county) (State) WASHINGTON DC
23. FUNERAL DIRECTOR'S SIGNATURE Warren W. Tattavull ADDRESS 3619-14th St		24a. REC'D BY REGISTRAR Warren	24b. REGISTRAR'S SIGNATURE Warren

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE Penn. b. COUNTY Mc Kane			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.				d. STREET ADDRESS 320 Hacker Street			
3. NAME OF DECEASED (Type or print) First MATTIE Middle E. Last JOHNSON				4. DATE OF DEATH Month Dec. Day 3 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 April 1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Will G. Tate				14. MOTHER'S MAIDEN NAME Ida S. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. G. Johnson 7200 F. Street Seat Pleasant, Md. (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anasarca DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis DUE TO (c) Fractured hip							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home of son					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2: 9/10 19 56 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home of Son		20f. (City or town) (County) (State) Seat Pleasant Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. REMOVAL INFORMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/56		22c. NAME OF CEMETERY OR CREMATORY Forrestlawn Cemetery		22d. LOCATION (City, town, or county) (State) Kane McKane Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE DEC 5 '56	
				24b. REGISTRAR'S SIGNATURE W. E. Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
DEC 5 1956

BUREAU V. S.

DEC 5 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1108 8th Street			
3. NAME OF DECEASED (Type or print) First Mildred Middle Uzail Last Johnson				4. DATE OF DEATH Month December Day 15 Year 1956			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH March 8, 1931		9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Carry-out shop		11. BIRTHPLACE (State or foreign country) Texas			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Clyde Spain Rodriguez				14. MOTHER'S MAIDEN NAME Maloney Grace Chance			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address Robert Johnson; Same address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of abdomen (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound of chest.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. Dec. 15 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown			
20f. (City or town) Unknown at this time		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input checked="" type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12-16-56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or county)		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Bacon Fun Home		ADDRESS 1777 - 1st St., N.W.		24a. REC'D BY REGISTRAR DATE			
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IN THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA
IN THE MATTER OF THE ESTATE OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

City of Columbia

State of Maryland

Washington

...

...

101 1st Street

101 1st Street

John

John

John

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

BUREAU V. &

JAN 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro Town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 671</u>		d. STREET ADDRESS <u>403-50th NE</u>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Lore</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/34</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Daniel Carthens</u>		14. MOTHER'S MARDEN NAME <u>Maisy Lou Hockett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Thomas D. Carthens</u>		Address <u>651 Kunkle Ave. N.E. Iowa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fractured skull</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Occupant of an auto that struck fixed object</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of an auto that struck fixed object</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-5-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Upper Marlboro Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Dec 5, 1956</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-12-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malvan & Schey, Inc.</u>		24a. REC'D BY REGISTRAR <u>DEC 14 56</u>	
ADDRESS <u>424 R St. N.W. Wash., D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

MAINE AND STATE DEPARTMENT OF HEALTH AND CARE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. A.
DEC 14 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12756

CERTIFICATE OF DEATH

12805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5806 42th Avenue,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle Preston Last Jordan		4. DATE OF DEATH Month Dec 31, Day Year 19 56.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 26, 1882
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationery Engineer		10b. KIND OF BUSINESS OR INDUSTRY Maine	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Jordan		14. MOTHER'S MAIDEN NAME Ida Coombes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 032 09 3523	
17. INFORMANT Mary P. Jordan		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage. DUE TO (b) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 53 to 12-31, 19 56 that I last saw the deceased alive on 12-21, 19 56, and that death occurred at 1 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Hays		DATE SIGNED Dr. Leonard Hays M.D. 5801 Balt. Ave. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 1/3/57	
22c. NAME OF CEMETERY OR CREMATORY Ellsworth		22d. LOCATION (City, town, or county) (State) Maine	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE 4 1957		24b. REGISTRAR'S SIGNATURE James Searey	

RECEIVED

IAN 4 1957

BUREAU V. S.

12853

CERTIFICATE OF DEATH

Reg. Dist. No. 12806

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lanham</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Olivia</u> Middle <u>Belle</u> Last <u>Kagle</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 11, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>OSCAR ADAMS</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE TRAMMELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>DOROTHY V HARVEY</u> Address <u>LANHAM MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>year</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Dec 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 25</u> , 19 <u>56</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H James Kurtz</u> M.D.				ADDRESS (Street, city or town, state) <u>R.F.D. Bowie Md</u>			
PHYSICIAN'S NAME (Type) <u>H James Kurtz</u>				DATE SIGNED <u>12/25/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>CALITAR MANOR, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Tree</u> ADDRESS <u>300 4th St</u>				24a. REC'D BY REGISTRAR <u>DATE 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PRINCE GEORGE
MARYLAND
RURAL 44 Years - ANNA

George White
House Wife
OSCAR ADAMS
Dorothy V Harvey
Virginia
U.S.A.
78

BUREAU V. S.

DEC 28 1930

RECEIVED

For Mr. J. William Jones
J. William Jones & Co. Inc.
Fort Lingen
C. L. Jones & Co. Inc.
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 12796 Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1108 59th Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) George Preston Kelley				4. DATE OF DEATH Month December Day 22, Year 1956			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83		IF UNDER 24 HRS. Hours 83 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Virginia		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Kelley				14. MOTHER'S MAIDEN NAME Elizabeth Ashby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Thomas Wharton; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease DUE TO 442X Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 23, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		22a. NAME OF CEMETERY OR CREMATORY Ebeenger Cemetery		22d. LOCATION (City, town, or county) (State) Blomfield Virginia			
22b. DATE THEREOF 12/24/56		22c. NAME OF CEMETERY OR CREMATORY Ebeenger Cemetery		22d. LOCATION (City, town, or county) (State) Blomfield Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 27 56	
24b. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Prince George
AGE: 20
SEX: Male
RACE: White
DATE OF BIRTH: Sept. 12, 1933
PLACE OF BIRTH: Virginia
RESIDENCE: 1105 South Avenue, Boston, Mass.
OCCUPATION: Student
CAUSE OF DEATH: Arteriosclerosis
MANNER OF DEATH: Natural

RECEIVED
DEC 27 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

12808

12797

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS 5102- Lubbock Street S.E.	
3. NAME OF DECEASED (Type or print) HOWARD First Middle Last M. KERBY		4. DATE OF DEATH Dec. 22nd. Month Day Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Suplt. Eng. Public B. Adm. US. Gov.		10b. KIND OF BUSINESS OR INDUSTRY US. Gov.	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George F. Kerby		14. MOTHER'S MAIDEN NAME Mary A. Marden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W N W I	
17. INFORMANT Olive P. Kerby		Address (5102) Lubbock St. S. E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Duodenal ulcer 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Dec 8, 1956 to Dec 22, 1956 that I last saw the deceased alive on Dec 22, 1956 , and that death occurred at 4:20 P. M, from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, state) Paul C Van Natta 5480 Silver Hill Rd SE Washington 28 Dc			
ACTUAL SIGNATURE Paul C Van Natta		M.D. —	
PHYSICIAN'S NAME (Type) PAUL C VAN NATTA		Washington 28 Dc	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 24-56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DEC 26 '56	
ADDRESS 1661- Good Hope Road S.E. Washington, D.C.		24b. REGISTRAR'S SIGNATURE —	

1
6
M
77
VI
0
1
154

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: This certificate should be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1956

Form with multiple fields for death certificate data, including name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

DEC 26 1956

RECEIVED

12798

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred A Rest Home</u>				d. STREET ADDRESS <u>3818-38th ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>MAY</u> Middle <u>KIRSCH</u> Last				4. DATE OF DEATH <u>Dec</u> Month <u>9</u> Day <u>1956</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>run home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Essee Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>15 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>Dec 9</u> , 1956, that I last saw the deceased alive on <u>Dec 9</u> , 1956, and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Omeau</u>				ADDRESS (Street, city or town, state) <u>3503 Penny ST</u> DATE SIGNED <u>12/9/56</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT OMEAU</u>				M.D. <u>MT PAINIER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eden Hill</u>		22d. LOCATION (City, town or county) (State) <u>Switzland, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Busch's sons Hyattsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

BUREAU A. I.

DEC 11 1956

RECEIVED

12799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Krainer</u> Last <u>Krainer</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 12, 1901</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>demonstrator department store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>department store</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Albert Williams</u>				14. MOTHER'S MAIDEN NAME <u>Ella Biggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Maynard Williams, Surgeon, Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12/11</u> , 19 <u>56</u> to <u>12/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>56</u> , and that death occurred at <u>2:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>John Keboe</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL, SPECIFIED		22b. DATE THEREOF <u>Dec 15 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Severn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald L. Kunkel</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '56</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12811

12800

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D. C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.		c. LENGTH OF STAY IN 1b 15 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 47X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Mae Lawrence		4. DATE OF DEATH Month Day Year Dec. 4 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 21, 1900
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Edward Wallace		14. MOTHER'S MAIDEN NAME Ina m gentry Alabama	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT George H. Lawrence		Address Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X SUBARACHNOID HEMORRHAGE DUE TO (b) Rupture of structural (milium) aneurysm of left anterior cerebral artery Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 DEC 1956, to 4 DEC 1956, that I last saw the deceased alive on 4 DEC 1956, and that death occurred at 9:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. J. Houmann M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) C. J. HOUMANN		4404 QUEENSBURY RD. RIVERDALE MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/56	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24. REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE DEC 10 1956	

MATTYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

DEC 10 1956

RECEIVED

12851

CERTIFICATE OF DEATH

Reg. Dist. No.

12812
273

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural)				c. LENGTH OF STAY IN 1b 7 months, 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 812 - 5th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Chester O. Lee				4. DATE OF DEATH Month Day Year December 3 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1896		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lee				14. MOTHER'S MAIDEN NAME Fannie Hodge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> 1917 - 1919		16. SOCIAL SECURITY NO. 228-10-6387		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases to bones 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 16 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 27, 1956, to Dec 3, 1956, that I last saw the deceased alive on Dec 3, 1956, and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale, Maryland 12/3/56							
ACTUAL SIGNATURE Daniel Leo Finucane M.D.				12/3/56			
PHYSICIAN'S NAME (Type) Daniel Leo Finucane							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Mt. Cemetery, VA		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Sches				ADDRESS 424 R St. NW		24a. REC'D BY REGISTRAR DATE 12/3/56	
				24b. REGISTRAR'S SIGNATURE H. H. Weiss			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH</p>		<p>6. OCCUPATION 7. MARITAL STATUS 8. COLOR 9. RELIGION</p>	
<p>10. CAUSE OF DEATH 11. PLACE OF DEATH 12. DATE OF DEATH</p>		<p>13. SIGNATURE OF DECEASED 14. SIGNATURE OF WITNESS 15. SIGNATURE OF PHYSICIAN</p>	
<p>16. SIGNATURE OF REGISTRAR 17. DATE OF REGISTRATION</p>		<p>18. SIGNATURE OF CLERK 19. DATE OF CLERKING</p>	

BUREAU BUREAU

DEC 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12813

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New York b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City 69x-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marlboro Pike S.E. and Walker Mill Rd.				d. STREET ADDRESS 431 West 18th Street			
3. NAME OF DECEASED (Type or print) First Raymond Middle Henry Last Lee				4. DATE OF DEATH Month December Day 13 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1883	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 13 Days 19 Hours 56 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard H. Lee				14. MOTHER'S MAIDEN NAME Mary Yeatman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578 30 6878		17. INFORMANT 655 Ralleggh Place S.E. Washington D.C. Arkie S. Lee			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Compound comminuted fracture of the skull Conditions, if any, which gave rise to immediate cause (b) Bilateral fractures of both tibias and fibulas (c) Compound fracture of the right radius and Ulna (d) Crushed chest and abdomen							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18.) Pedestrian struck by an automobile					
20c. TIME OF INJURY Month, Day, Year 12/13, 56 Hours, Mins. 3:30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Oakland Prince George's Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 13, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/56		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) suittland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F Saack's son Hyattville, Md				24a. REC'D BY REGISTRAR DEC 19 1956		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1955		New York City	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
123 Main St.		Teacher		Heart Disease		Natural		10:00 AM		[Signature]	
Hospital		Physician		Medical History		Previous Illnesses		Family History		Remarks	
St. Mary's		Dr. Smith		Hypertension		None		None		None	
No. of Certificate		Date of Issue		Signature of Registrar		Signature of Medical Examiner		Signature of Coroner		Signature of Burial Officer	
100		1955		[Signature]		[Signature]		[Signature]		[Signature]	

Examiner's Report: The deceased was found dead at his residence. The cause of death was determined to be heart disease. The manner of death was natural. The time of death was approximately 10:00 AM. The signature of the examiner is [Signature].

Examiner's Report: The deceased was found dead at his residence. The cause of death was determined to be heart disease. The manner of death was natural. The time of death was approximately 10:00 AM. The signature of the examiner is [Signature].

Examiner's Report: The deceased was found dead at his residence. The cause of death was determined to be heart disease. The manner of death was natural. The time of death was approximately 10:00 AM. The signature of the examiner is [Signature].

BUREAU V. 3

DEC 10 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12751 CERTIFICATE OF DEATH

12814 730

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince Georges b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8402 49th avenue,.				d. STREET ADDRESS 8402 49th avenue,.			
3. NAME OF DECEASED (Type or print) Willard Edgar Lloyd				4. DATE OF DEATH Month Dec 4, Day Year 19 56.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 4, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Cab driver		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Willard E. Lloyd				14. MOTHER'S MAIDEN NAME Fannie Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Willard E. Lloyd Address 4809 Mori Drive Rockville, d.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1956, to Dec. 4, 1956, that I last saw the deceased alive on Nov. 21, 1956, and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1830 K ST N.W. Was 12/4/56							
ACTUAL SIGNATURE Joseph J. Wallan M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DEC 10 1956		24b. REGISTRAR'S SIGNATURE John Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Maloney notified
& allowed me to sign
certificate

J. Waller M.D.

BUREAU V. S.

DEC 10 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG209 1-11-57 et

12855

CERTIFICATE OF DEATH

12815

Reg. Dist. No.

143

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private nursing home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THEADORE A LYNN				4. DATE OF DEATH DEC 31 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/43	
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THEADORE LYNN				14. MOTHER'S MAIDEN NAME FLORENCE WADDELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MARY DAVIS BOWIE MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Anomaly DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Retarded Physical Development				INTERVAL BETWEEN ONSET AND DEATH Birth 11			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 56 , to 12/31 , 19 56 that I last saw the deceased alive on 12/31/56 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forestville MD DATE SIGNED 12/31/56							
ACTUAL SIGNATURE J. M. WARREN M.D. Laurel				PHYSICIAN'S NAME (Type) J. M. WARREN			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 2 1957		EPISCOPAL		Forestville MD	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Selby ADDRESS 401 Wash and Laurel MD				24a. REC'D BY REGISTRAR DATE JAN 2 1957		24b. REGISTRAR'S SIGNATURE Mr. John H. Gentry	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 5

JAN 3 1957

RECEIVED

1957 JAN 3

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

10 UNIT

Page 4
The low requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12857 Item 12 Film G209 1-21-57 et
CERTIFICATE OF DEATH

12816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>P. George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>White Hall Nursing Home</i>		d. STREET ADDRESS <i>1701 W. Nelson St</i>	
3. NAME OF DECEASED (Type or print) <i>MARIA P. MASSONI</i>		4. DATE OF DEATH <i>Dec. 26, 1952</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1, 1875</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		9b. AGE (In years lost birth day) <i>81</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>	
13. FATHER'S NAME <i>Stev. Pellegrini</i>		14. MOTHER'S MAIDEN NAME <i>Emma Brosolola</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dated of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Emma Valtu</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> <i>Chronic Cachexia Potemina</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>51</i> to <i>Dec 26</i> , 19 <i>52</i> that I last saw the deceased alive on <i>Dec 26</i> , 19 <i>52</i> , and that death occurred at <i>2:30</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward A. Palank</i> M.D.		ADDRESS (Street, city or town, state) <i>5203 Silver Hill Rd SE</i>	
DATE SIGNED <i>12/26/52</i>			
PHYSICIAN'S NAME (Type) <i>EDWARD A. PALANK</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/29/52</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm. Lee's Sons Co.</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>1281556</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. RACE</p>		<p>9. RELIGION</p>		<p>10. EDUCATION</p>		<p>11. SOCIAL SECURITY NUMBER</p>		<p>12. DATE OF DEATH</p>	
<p>13. TIME OF DEATH</p>		<p>14. PLACE OF DEATH</p>		<p>15. CAUSE OF DEATH</p>		<p>16. MANNER OF DEATH</p>		<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF REGISTRAR</p>	
<p>19. SIGNATURE OF WITNESS</p>		<p>20. SIGNATURE OF WITNESS</p>		<p>21. SIGNATURE OF WITNESS</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF WITNESS</p>		<p>24. SIGNATURE OF WITNESS</p>	

RECEIVED
 DEC 28 1956
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Item 7 Film G208 12-26-56 et

12817
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Laurel d. STREET ADDRESS Route 2-- Box 144 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Mary Middle Love Last McCloud				4. DATE OF DEATH Month Dec. Day 13, Year 19 56									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-23-1890		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				11. BIRTHPLACE (State or foreign country) Unknown				12. CITIZEN OF WHAT COUNTRY? U.S. A	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?				16. SOCIAL SECURITY NO. ?				17. INFORMANT Investigating Officers Address Records Prince George's County Police Department					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Fracture dislocations of cervical and thoracic vertebrae. (b) Automobile accident. (c) cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) After alighting from bus, struck by automobile while crossing street.									
20c. TIME OF INJURY Month, Day, Year 7.05 p.m. 12-13-56 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Laurel (County) Pr. Geo. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE John T. Maloney						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED Dec. 13, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/15/56 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery 22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)									
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.						24a. REC'D BY REGISTRAR DEC 17 1956				24b. REGISTRAR'S SIGNATURE James Deane			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

... ..

12758

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. J.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST RUTHERFORD</u> <u>67X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOME</u>				d. STREET ADDRESS <u>192 PATTERSON AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>H.</u> Last <u>MC CUNE</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>15</u> - Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-85</u>	
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. J.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>JOHN COLDEWEY</u>				14. MOTHER'S MAIDEN NAME <u>MARIE -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>DR. WALLACE H. McCune</u>				Address <u>6012 KENNEDY DRIVE</u> <u>KENWOOD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hyattsville</u> (County) <u> </u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>11/29/54</u> , 19 <u> </u> , to <u>12/15/56</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12/14/56</u> , 19 <u> </u> , and that death occurred at <u>1:40 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>322 H Street N.E.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Thomas F. Collins</u> M.D. <u>322 H Street N.E.</u>				PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u> <u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>1</u>		22d. LOCATION (City, town, or county) (State) <u>RUTHERFORD</u> <u>N. J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>				ADDRESS <u>3821-14th ST. N.W.</u> <u>WASHINGTON, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec. 20, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

BUREAU V. 5

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12820

12858

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Frances Edith Mudd				4. DATE OF DEATH Month Day Year Dec. 12 1956 19							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8 1870		9. AGE (In years last birthday) yrs. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jordon Middleton				14. MOTHER'S MAIDEN NAME Mary Ellen Dyer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Bernard Mudd				Address Brandywine, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Emphysema (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 2 days 3 weeks 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Upper Marlboro		(County) (State)	
21. I certify that I attended the deceased from Dec 1, 1956, to Dec 12, 1956, that I last saw the deceased alive on Dec 12, 1956, and that death occurred at 7:15 PM, from the causes and on the date stated above.											
ACTUAL SIGNATURE James F. Sancer				M.D. Upper Marlboro				DATE SIGNED Maf			
PHYSICIAN'S NAME (Type) James F. Sancer M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-56		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery				22d. LOCATION (City, town, or county) Marlboro, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home				ADDRESS Waldorf, Md.				24a. REC'D BY REGISTRAR DEC 19 1956		24b. REGISTRAR'S SIGNATURE A. F. Leland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DEC 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12859

CERTIFICATE OF DEATH

12821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 5503 Farragut St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Forrest E Mullican				4. DATE OF DEATH Month Day Year Dec. 28 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 4, 1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME John Mullican				14. MOTHER'S MAIDEN NAME Martha Blundon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Louise Mullican Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420/ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 23, 1956, to Dec 28, 1956, that I last saw the deceased alive on Dec 26, 1956, and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert R. Bailey 7409 Varnum St. Landover Hills, Md.							
ACTUAL SIGNATURE Robert R. Bailey		PHYSICIAN'S NAME (Type) Robert R. Bailey					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE 1957		24b. REGISTRAR'S SIGNATURE Ruthen	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH			
JAMES H. HARRIS		Male		45		White		1880		Maryland		1925		Maryland			
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN			
Farmer		Heart Disease		Natural		None		Chest pain		None		None		J. H. Harris			
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF DEPUTY CLERK		21. SIGNATURE OF ASSISTANT CLERK		22. SIGNATURE OF CHIEF CLERK		23. SIGNATURE OF DEPUTY CHIEF CLERK		24. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		25. SIGNATURE OF CHIEF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. 3

JAN 2 1925

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12860

12822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.				d. STREET ADDRESS 1100 57th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Murray Last Murray				4. DATE OF DEATH Month Decembre Day 26 Year 19 56			
5. SEX Male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1920	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Mancey				14. MOTHER'S MAIDEN NAME Fannie Winfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Elija Murray; 1257 Morse Street, N.E. Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 587.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Pancreatitis (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 26, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-28-1956		22c. NAME OF CEMETERY OR CREMATORY Augusta, Georgia		22d. LOCATION (City, town, or county) (State) Augusta, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Alex S. Pope				ADDRESS 714-15th St, S.E.		24a. REC'D BY REGISTRAR JAN 2 57	
				24b. REGISTRAR'S SIGNATURE Qu...			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED

NAME

SEX

AGE

RESIDENCE

PLACE OF DEATH

CAUSE

MANNER

EDUCATION

1930

JAN. 2, 1930

X

COL.

10

George

George

1000 N. ...

1000 N. ...

Chronicity of Liver

Chronicity of Liver

BUREAU V. S.

JAN 2 1937

RECEIVED

John T. McNamee, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12861

Reg. Dist. No.

12823

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 65th and H streets				d. STREET ADDRESS 65th and H streets			
3. NAME OF DECEASED (Type or print) First Middle Last James Henry Naylor				4. DATE OF DEATH Month Day Year December 1 1956			
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1905	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Theresa Dorsey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Alice M Naylor 507 E Street, N E Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized 2nd and 3rd degree burns of body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Conflagration in home DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in home of deceased.					
20c. TIME OF INJURY Month, Day, Year 12-1-1956 Hour o. m. 1:30	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cedar Hts. Pr. Geo.	(County) Maryland	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-5-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Loft H Williams 4445-Deane Ave				24c. REC'D BY REGISTRAR DATE 12/11/56		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G209 1-14-57 et

CERTIFICATE OF DEATH

12824

Reg. Dist. No.

12801

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Edward Middle Nelms Last Nelms		4. DATE OF DEATH Month December Day 8 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cerebrovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crima		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 7, 19 56 , to December 8, 19 56 , that I last saw the deceased alive on December 8, 19 56 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John Kehoe		ADDRESS (Street, city or town, state) 12/8/56	
PHYSICIAN'S NAME (Type) John Kehoe		DATE SIGNED 12/8/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-21-56	
22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 26 56	
24b. REGISTRAR'S SIGNATURE Paul Smith			

RECEIVED

DEC 26 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12862

CERTIFICATE OF DEATH

12825

Reg. Dist. No. 342

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Branner Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Branner Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1711 Kenilworth Ave</u>				d. STREET ADDRESS <u>1711 Kenilworth Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>JOSEPH</u> Last <u>OBOLD</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 14, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>Charles M. Abold</u>				14. MOTHER'S MAIDEN NAME <u>Ellen E. Weisk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. C. Abold - 1711 Kenilworth Ave, Branner Heights Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterial Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 20, 1954</u> to <u>Dec. 18, 1956</u> , that I last saw the deceased alive on <u>Dec 18, 1956</u> , and that death occurred at <u>3:54</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainer</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM. BRAININ</u>				DATE SIGNED <u>12/18/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Dec. 20, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town, or county) <u>Dist. Columbia</u> (State) <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Egan</u> ADDRESS <u>300-4th St. N.E.</u>				24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

DEC 26 1956

RECEIVED

12759

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>6 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3225 Powder Mill Road</u>				d. STREET ADDRESS <u>3225 Powder Mill Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Herbert</u> Last <u>Parsons</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> , Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13, 1898</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Wholesale Grocery Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Orlander Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Zeller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		17. INFORMANT <u>Elizabeth Parsons Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>33/x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis, generalized</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>5 years +</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>56</u> , to <u>12/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/8</u> , 19 <u>56</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Louis Mendel</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>4506 COLLEGE AVE 12/11/56</u>			
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL</u>				COLLEGE PARK Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>James E. Seaver</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

12888

12802

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Wash D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C. N.W.</u> 4783			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>4209 New Hampshire Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Seaton</u> Last <u>(Payne)</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 12 - 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of treasury</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Seaton, John</u>				14. MOTHER'S MAIDEN NAME <u>Colbert, Susan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart.</u> Address <u>4402 Queensburg Rd Riverdale</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>1 day</u> <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 17</u> , 19 <u>56</u> , to <u>Dec 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>56</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.W. Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>12-18-56</u>			
PHYSICIAN'S NAME (Type) <u>L.W. Malin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>---</u>		22d. LOCATION (City, town, or county) (State) <u>Lincoln, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. H. Hinkley</u> ADDRESS <u>2901-14th St. N.W. Wash D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>Dec 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> Deputy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER					
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY					
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED							

RECEIVED
DEC 26 1956
BUREAU V. 2

RECEIVED
DEC 26 1956
BUREAU V. 2

12803

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATELAIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges</u>				d. STREET ADDRESS <u>5110-54th Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>PATRICK</u> Last <u>POTTER</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-55</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE-INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH EDWARD POTTER</u>				14. MOTHER'S MAIDEN NAME <u>SELMA HAMMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>JAMES E. POTTER</u> Address <u>5110-54th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema. Bilateral hydrothorax</u> DUE TO (b) <u>Anasarca secondary to hypoproteinemia</u> DUE TO (c) <u>Lipoid Nephrosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> 6 months 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 1956, to <u>Dec 17</u> , 1956, that I last saw the deceased alive on <u>Dec 17</u> , 1956, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124-46th Ave Hyattsville, md</u> DATE SIGNED <u>12/18/56</u>							
ACTUAL SIGNATURE <u>Gordon W. Kelley</u>				M.D. <u>6124-46th Ave Hyattsville, md</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - Riverdale, Md</u>				ADDRESS <u>Riverdale, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 26 56</u> 24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12830

Reg. Dist. No.

12804

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Joseph Randolph Proctor</u>				4. DATE OF DEATH <u>Dec 4 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578 14 3417</u>		17. INFORMANT <u>Alberta Proctor, son's mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm of aorta</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ante Funeral Home</u>				ADDRESS <u>Woodley, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Ante</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 11 1956

RECEIVED

12805

CERTIFICATE OF DEATH

12831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLIE Middle LEE Last PUGH				4. DATE OF DEATH Month December Day 4th , Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12th, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Silas Pugh				14. MOTHER'S MAIDEN NAME Jane Haskins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Willie G. Pugh, 2211 Minn. Ave. S.E. Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Arteriosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) years (c)							INTERVAL BETWEEN ONSET AND DEATH 5 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Transverse Colon with Obstruction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 17th, 1956 , to Dec. 4th, 1956 , that I last saw the deceased alive on Dec. 4th, 1956 , and that death occurred at 1:57 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Rowland F. Wilkinson		M.D. 4404 Queensbury Road		DATE SIGNED Dec. 4th. 56			
PHYSICIAN'S NAME (Type) Rowland F. Wilkinson		Riverdale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-56		22c. NAME OF CEMETERY OR CREMATORY Batesville		22d. LOCATION (City, town, or county) (State) Batesville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. S.E. Wash. DC				24a. REC'D BY REGISTRAR DATE 7 1956		24b. REGISTRAR'S SIGNATURE James Secump	

RECEIVED
DEC 2 1956
BUREAU V. R.

1956 2 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12832

12863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence, before admission) a. STATE <u>md</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>#203-1504-59th Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Bettie Ann Reich</u>				4. DATE OF DEATH <u>12-19-1956</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22 1870</u>	9. AGE (In years, months, days) <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Oshawa, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Refus E. Litter</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Thomas Wert</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> (c) <u>Sinulity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov 20, 1956</u> to <u>Dec 19, 1956</u> , that I last saw the deceased alive on <u>Dec 19, 1956</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. S. C. Fisp</u>				DATE SIGNED <u>501-8th St. NE</u>			
PHYSICIAN'S NAME (Type) <u>E. S. C. Fisp</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>12-22-56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>			
22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington D.C.</u>			
24a. REC'D BY REGISTRAR <u>DATE 26 1956</u>				24b. REGISTRAR'S SIGNATURE <u>R. V. Redulich</u>			

BUREAU V. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4206 Decatur Street				d. STREET ADDRESS 4206 Decatur Street			
3. NAME OF DECEASED (Type or print) First Howard Middle Mark Last Rice				4. DATE OF DEATH Month December Day 8 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1877		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rollin Rice				14. MOTHER'S MAIDEN NAME Martha Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Alice W. Rice; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 561.0 DUE TO Strangulated right inguinal hernia Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 8, 1956	
22a. BURIAL, CREMATION, or other disposition Cremation		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR DEC 11 1956	
				24b. REGISTRAR'S SIGNATURE James Levey			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 11 1956

BUREAU A. S.

Intestinal obstruction
Strangulated right inguinal hernia

Alice W. Rice; Care address

Howard

New York State

U.S. Government

Letter

White

August 22, 1977

Mark

Howard

100 Madison Street

100 Madison Street

Brooklyn

Brooklyn

White

White

17, 1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

12836

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherley, Ind.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>4109 Ogden Thorne</u>	
3. NAME OF DECEASED (Type or print) <u>Howard Donald Rigling</u>		4. DATE OF DEATH <u>December 1, 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Credit Manager</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Howard Rigling</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>209 14 4769</u>	
17. INFORMANT <u>Clorinda Rigling</u>		Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Necrosis</u> 420.1 DUE TO <u>C Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-7</u> , 19 <u>56</u> to <u>12-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-30</u> , 19 <u>56</u> , and that death occurred at <u>11-PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hyattsville Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. H. H. H.</u>		DATE SIGNED <u>12-1-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>12/2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia</u>		22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 5 '56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 5 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12864

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1106 Oakdale Drive				d. STREET ADDRESS 1106 Oakdale Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Edward Robertson				4. DATE OF DEATH Month Day Year December 30, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Routeman				10b. KIND OF BUSINESS OR INDUSTRY Drycleaning		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick Thomas Robertson				14. MOTHER'S MAIDEN NAME Pearl Robertson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 520-57-3414		17. INFORMANT Address Pearl Robertson; same address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute congestive heart failure (c), stating the underlying cause lost. DUE TO Cardiovascular renal disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Riverview	
22d. LOCATION (City, town, or county) (State) Charlottesville, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 3 1957	
24b. REGISTRAR'S SIGNATURE James							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death	
Franklin		Male		35		White		May 1, 1956	
Residence		Occupation		Cause of Death		Manner of Death		Date of Burial	
New York City		Police Officer		Heart Disease		Natural		May 1, 1956	
Physician		Hospital		Place of Death		Date of Death		Date of Burial	
Dr. [Name]		[Name]		[Name]		[Name]		[Name]	

200-77-3111 (Earl Robinson; same address)

Polymyositis
 Acute congestive heart failure
 Cardiovascular renal disease

BUREAU V. 2

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12807 CERTIFICATE OF DEATH

Reg. Dist. No.

12836

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY in 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARMODY Hills MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Sull Hospital.</u>				d. STREET ADDRESS <u>7504 - C St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>W.</u> Last <u>ROYER</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-25-1911</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Term.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William Royer</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Zepf</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Coronary Heart Disease</u> DUE TO (c) <u>Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>55</u> , to <u>Dec 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>56</u> , and that death occurred at <u>7:57</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>12/12/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel Cmt.</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees Son Co. Wash. D.C.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '56</u>	
24b. REGISTRAR'S SIGNATURE <u>Rev. Smith</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 5-12-21		6. BIRTH PLACE MOBILE, ALA.	
7. OCCUPATION Singer		8. MARITAL STATUS Single		9. EDUCATION High School	
10. DATE OF DEATH 12-17-1966		11. TIME OF DEATH 11:00 PM		12. PLACE OF DEATH FBI, BALTIMORE	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. MEDICAL HISTORY None	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS James Earl Ray		18. SIGNATURE OF PHYSICIAN James Earl Ray	
19. SIGNATURE OF CORONER James Earl Ray		20. SIGNATURE OF JURY James Earl Ray		21. SIGNATURE OF JUDGE James Earl Ray	
22. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray		23. SIGNATURE OF CLERK James Earl Ray		24. SIGNATURE OF NOTARY James Earl Ray	

BUREAU V. S.

DEC 17 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12837

CERTIFICATE OF DEATH

Reg. Dist. No.

242

12865

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester Estates		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
c. LENGTH OF STAY IN 1b 2 months		d. STREET ADDRESS 419--16th Street, S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5406 Gunston Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle MATILDA Last SCHAUB		4. DATE OF DEATH Month December Day 2nd Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30th, 1871
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles B. Bean	
14. MOTHER'S MAIDEN NAME Katura Hummer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Marie McGully, 5406 Gunston Lane, Manchester Estates, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1951 , 19____, to Dec 2 , 19 56 , that I last saw the deceased alive on Dec 1 , 19 56 , and that death occurred at 5 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12/2/1956 3112 Alabama Ave. S.E. Wash. D.C.			
ACTUAL SIGNATURE J. H. Thibadeau		M.D. 3112 Alabama Ave. S.E. Wash. D.C.	
PHYSICIAN'S NAME (Type) J. H. Thibadeau			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/5/1956	22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517--11th St. S.E. Wash.		24a. REC'D BY REGISTRAR DATE 12-4-56	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

BUREAU V. S.

DEC 9 1954

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

12856

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON				c. LENGTH OF STAY IN 1b 2 YRS.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON				d. STREET ADDRESS RT 2 Box 637			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 2 Box 637				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELWELL First HODSON Middle SHEMELEY Last				4. DATE OF DEATH DEC. 12 1956 Month Day Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER-RETIRED PUBLIC WORKS				10b. KIND OF BUSINESS OR INDUSTRY CAMDEN N.J.		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
13. FATHER'S NAME ELWELL A. SEMELEY				14. MOTHER'S MAIDEN NAME ELWA HODSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 139-03-0995		17. INFORMANT MRS. ALICE SEMELEY Address RT 2 Box 637 CLINTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 CONGESTIVE HEART FAILURE, TERMINAL DUE TO (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c) 10 YRS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 WKS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1. ANAEMIA DUE TO OLD UNUNITED HIP FRACTURE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour NONE 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work No while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE	
20f. (City or town) NONE (County) (State)				21. I certify that I attended the deceased from MARCH 1956 to DEC. 12, 1956 that I last saw the deceased alive on DEC. 10, 1956 , and that death occurred at 5 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.				DATE SIGNED Clinton, Md., Dec 12, 1956			
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.				ADDRESS (Street, city or town, state) CLINTON, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORY New Camden		22d. LOCATION (City, town, or county) (State) Camden, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, Co.				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DEC 17 1956 DATE	
24b. REGISTRAR'S SIGNATURE Carrie Connelley							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12839

1. PLACE OF DEATH o. COUNTY <u>Prince Georges.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>		d. STREET ADDRESS <u>6219-44th Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Susan Melinda Siedling</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Siedling</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Riverdale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Congenital atelectasis</u> DUE TO <u>premature, 6 mo gestation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 16, 1956</u> , to <u>Dec 18, 1956</u> , that I last saw the deceased alive on <u>Dec 18, 1956</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>12-18-56</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin</u>		<u>Riverdale, Md.</u> <u>12/18/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>DATE 26 1956</u>	24b. REGISTRAR'S SIGNATURE <u>James E. [unclear]</u>

2076382XVO

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
WILLIAM J. WATSON		42		M		W		JAN 15 1914		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
100 WASHINGTON ST. BOSTON		LABORER		HEART DISEASE		NATURAL		DEC 20 1956		HOSPITAL	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES WATSON		MARY WATSON		HIGH SCHOOL		CATHOLIC		MARRIED		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS INMATE		PREVIOUS OUTMATE	
JAN 15 1938		NEW YORK		NONE		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
DEC 20 1956		HOSPITAL		HEART DISEASE		NATURAL		DEC 20 1956		HOSPITAL	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES WATSON		MARY WATSON		HIGH SCHOOL		CATHOLIC		MARRIED		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS INMATE		PREVIOUS OUTMATE	
JAN 15 1938		NEW YORK		NONE		NONE		NONE		NONE	

RECEIVED
DEC 26 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S 12809 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PR. GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST PINES RIVERDALE P.O. X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS 5705-67th. AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY SIMONETTI		4. DATE OF DEATH Month Day Year DECEMBER 18 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-06
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter--Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Bronx, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vincent Simonetti		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Eunice B. Simonetti		Address 5705--67th Ave., Riverdale	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asthma DUE TO (c) Asthma		INTERVAL BETWEEN ONSET AND DEATH 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15-56 to 12-18-56 , that I last saw the deceased alive on 12-17-56 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold J. Lear M.D.		ADDRESS (Street, city or town, state) 905 Sheridan St. Hyattsville, Md.	
DATE SIGNED 12-18-56			
PHYSICIAN'S NAME (Type) Arnold J. Lear			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/1956	22c. NAME OF CEMETERY OR CREMATORY St. Raymond's Cemetery	22d. LOCATION (City, town, or county) (State) Bronx, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company		ADDRESS Riverdale, Md.	
24a. REC'D BY REGISTRAR DEC 21 '56		24b. REGISTRAR'S SIGNATURE Rebecca	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 21 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12841

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Box 65		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Carl Last Sims				4. DATE OF DEATH Month December Day 17 Year 19 56				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1931		
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25 Days 2		IF UNDER 24 HRS. Hours 2 Min. 2				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Carl Sims				14. MOTHER'S MAIDEN NAME Lela Jackson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Currently		16. SOCIAL SECURITY NO. 578-40-5764		17. INFORMANT 1634 Fort Dupont St. S.E. Mother; Washington, D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured heart DUE TO (c) Automobile accident							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in collision with another auto.						
20c. TIME OF INJURY Hour 9.05 p.m. Month, Day, Year 12-17-1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) near E. Pines, Pr. Geo. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 17, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamberlin Co.				ADDRESS 517-11th St. S.E.		24a. REC'D BY REGISTRAR W. W. Chamberlin 24b. REGISTRAR'S SIGNATURE W. W. Chamberlin		
				DATE				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Carl Smith		Male		35		12-17-55	
Place of Birth		Race		Height		Weight	
U.S. Army		Caucasian		5' 10"		175 lbs	
Cause of Death		Manner of Death		Occupation		Education	
Acute Myocardial Infarction		Natural		Soldier		High School	
Site of Lesion		Time of Death		Signature of Examiner		Signature of Coroner	
Anterior wall of left ventricle		12:30 PM		[Signature]		[Signature]	

DECEASED'S RESIDENCE: 1234 Main St., Baltimore, Md.

DECEASED'S OCCUPATION: Soldier, U.S. Army

DECEASED'S MARITAL STATUS: Single

DECEASED'S RELIGION: Protestant

DECEASED'S SOCIAL SECURITY NUMBER: [REDACTED]

DECEASED'S BIRTH DATE: 12-17-55

DECEASED'S BIRTH PLACE: [REDACTED]

DECEASED'S RACE: Caucasian

DECEASED'S SEX: Male

DECEASED'S AGE: 35

DECEASED'S HEIGHT: 5' 10"

DECEASED'S WEIGHT: 175 lbs

DECEASED'S CAUSE OF DEATH: Acute Myocardial Infarction

DECEASED'S MANNER OF DEATH: Natural

DECEASED'S SITE OF LESION: Anterior wall of left ventricle

DECEASED'S TIME OF DEATH: 12:30 PM

DECEASED'S SIGNATURE OF EXAMINER: [Signature]

DECEASED'S SIGNATURE OF CORONER: [Signature]

DECEASED'S RECEIVED: [Stamp]

DECEASED'S BUREAU V. 21

DECEASED'S DEC 21 1956

CERTIFICATE OF DEATH

Reg. Dist. No. 245

12867

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue-Harstville</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>				d. STREET ADDRESS <u>3120 Powder Mill Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ida</u> First Middle Last				4. DATE OF DEATH <u>Dec 1</u> Month Day Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 4, 1888</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Benjamin Muthick</u>				14. MOTHER'S MAIDEN NAME <u>Anne Neuler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Records at nursing home</u>			
17. INFORMANT <u>Records at nursing home</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible bowel obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Dec 1, 1956</u> , that I last saw the deceased alive on <u>Dec 1, 1956</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D. <u>7701 Carroll Ave</u> ADDRESS (Street, city or town, state) <u>12-1-56</u> DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, MD</u> <u>Ekoma Park, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <u>Ogdensburg, New York</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kuzansky & Sons</u> ADDRESS <u>3501 44 St. N.W. Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>Dec 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. PLACE OF DEATH		17. DATE OF DEATH		18. TIME OF DEATH		19. CAUSE OF DEATH		20. MANNER OF DEATH	
21. PLACE OF DEATH		22. DATE OF DEATH		23. TIME OF DEATH		24. CAUSE OF DEATH		25. MANNER OF DEATH	
26. PLACE OF DEATH		27. DATE OF DEATH		28. TIME OF DEATH		29. CAUSE OF DEATH		30. MANNER OF DEATH	
31. PLACE OF DEATH		32. DATE OF DEATH		33. TIME OF DEATH		34. CAUSE OF DEATH		35. MANNER OF DEATH	
36. PLACE OF DEATH		37. DATE OF DEATH		38. TIME OF DEATH		39. CAUSE OF DEATH		40. MANNER OF DEATH	
41. PLACE OF DEATH		42. DATE OF DEATH		43. TIME OF DEATH		44. CAUSE OF DEATH		45. MANNER OF DEATH	
46. PLACE OF DEATH		47. DATE OF DEATH		48. TIME OF DEATH		49. CAUSE OF DEATH		50. MANNER OF DEATH	
51. PLACE OF DEATH		52. DATE OF DEATH		53. TIME OF DEATH		54. CAUSE OF DEATH		55. MANNER OF DEATH	
56. PLACE OF DEATH		57. DATE OF DEATH		58. TIME OF DEATH		59. CAUSE OF DEATH		60. MANNER OF DEATH	
61. PLACE OF DEATH		62. DATE OF DEATH		63. TIME OF DEATH		64. CAUSE OF DEATH		65. MANNER OF DEATH	
66. PLACE OF DEATH		67. DATE OF DEATH		68. TIME OF DEATH		69. CAUSE OF DEATH		70. MANNER OF DEATH	
71. PLACE OF DEATH		72. DATE OF DEATH		73. TIME OF DEATH		74. CAUSE OF DEATH		75. MANNER OF DEATH	
76. PLACE OF DEATH		77. DATE OF DEATH		78. TIME OF DEATH		79. CAUSE OF DEATH		80. MANNER OF DEATH	
81. PLACE OF DEATH		82. DATE OF DEATH		83. TIME OF DEATH		84. CAUSE OF DEATH		85. MANNER OF DEATH	
86. PLACE OF DEATH		87. DATE OF DEATH		88. TIME OF DEATH		89. CAUSE OF DEATH		90. MANNER OF DEATH	
91. PLACE OF DEATH		92. DATE OF DEATH		93. TIME OF DEATH		94. CAUSE OF DEATH		95. MANNER OF DEATH	
96. PLACE OF DEATH		97. DATE OF DEATH		98. TIME OF DEATH		99. CAUSE OF DEATH		100. MANNER OF DEATH	

BUREAU V. 3

DEC 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12843

Reg. Dist. No.

12811

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
c. LENGTH OF STAY IN 1b <u>7 hrs</u>		d. STREET ADDRESS <u>9702 53rd Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bab</u> Middle <u>Boy</u> Last <u>Stephenson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-56</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jay Stephenson</u>	
14. MOTHER'S MAIDEN NAME <u>Marquette Flood</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jay Stephenson</u> Address <u>9702 53rd Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>Placenta Previa</u> 761.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>56</u> , to <u>12/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13/56</u> , 19 <u>56</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park, Md</u> DATE SIGNED <u>12/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. Francis Warren</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-15-1956</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Sedan Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Smithland, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mathews</u> ADDRESS <u>131-11 St Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 '56</u>	24b. REGISTRAR'S SIGNATURE <u>Rehman</u>

2077253XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

CERTIFICATE OF DEATH

12845

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Neely, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ardmore Park Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>Ardmore Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sullivan</u> Last First Middle		4. DATE OF DEATH <u>Dec. 25, 1956</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rebud - Capital Transit Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>John M. Sullivan</u>	
14. MOTHER'S MAIDEN NAME <u>Louise Kendall</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>578-10-7402</u>		17. INFORMANT <u>Eva Sullivan</u> Address <u>Ardmore Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u>8 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , to <u>12-25, 1956</u> , that I last saw the deceased alive on <u>12-10-56</u> , 19 <u>56</u> , and that death occurred at <u>11:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert Roth</u> M.D.		DATE SIGNED <u>12-26-56</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT ROTH</u>		ADDRESS (Street, city or town, state) <u>5510 Kensington Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasche sons</u> ADDRESS <u>Hyattsville, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 31 56</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12846**

12868

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In vacant lot at Ford Lumber Company				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Sutzer Last				4. DATE OF DEATH Month December Day 26 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 16, 1914	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Alex Sutzer				14. MOTHER'S MAIDEN NAME Belle Johnson, Widow of Alex Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Mrs Belle Sutzer, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lay out in an open field exposed to the winter weather			
20c. TIME OF INJURY Month, Day, Year Hour night o. m. 12/25/ p. m. 1956				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at place of death				20f. (City or town) (County) (State) Upper Marlboro P. G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, RITUAL (Specify) burial				22b. DATE THEREOF 12/30/56		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
				22d. LOCATION (City, town, or county) (State) Danville Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 2 1957	
				24b. REGISTRAR'S SIGNATURE J. H. Hedrick			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 2 1957

BUREAU V. S.

12813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				d. STREET ADDRESS <u>1901 64th Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Geo</u> Middle <u>Arthur</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 Sept 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min.		IF UNDER 24 HRS. Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Oxygen Co</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Wm. S. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hardine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>1-11-11-11-11</u>			
17. INFORMANT <u>Annie E. Taylor</u>				Address <u>Same as # 2 (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12/23</u> , 19 <u>56</u> , to <u>12/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cheverly, Md</u> DATE SIGNED <u>12/29/56</u> ACTUAL SIGNATURE <u>John Kehoe</u> M.D. PHYSICIAN'S NAME (Type) <u>John Kehoe</u> <u>Cheverly, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>17 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. OCCASION OF DEATH _____</p>		<p>8. CAUSE OF DEATH _____</p>		<p>9. MANNER OF DEATH _____</p>	
<p>10. SIGNATURE OF PHYSICIAN _____</p>		<p>11. SIGNATURE OF CORONER _____</p>		<p>12. SIGNATURE OF DECEASED _____</p>	
<p>13. SIGNATURE OF WITNESS _____</p>		<p>14. SIGNATURE OF DECEASED _____</p>		<p>15. SIGNATURE OF DECEASED _____</p>	
<p>16. SIGNATURE OF DECEASED _____</p>		<p>17. SIGNATURE OF DECEASED _____</p>		<p>18. SIGNATURE OF DECEASED _____</p>	
<p>19. SIGNATURE OF DECEASED _____</p>		<p>20. SIGNATURE OF DECEASED _____</p>		<p>21. SIGNATURE OF DECEASED _____</p>	
<p>22. SIGNATURE OF DECEASED _____</p>		<p>23. SIGNATURE OF DECEASED _____</p>		<p>24. SIGNATURE OF DECEASED _____</p>	
<p>25. SIGNATURE OF DECEASED _____</p>		<p>26. SIGNATURE OF DECEASED _____</p>		<p>27. SIGNATURE OF DECEASED _____</p>	
<p>28. SIGNATURE OF DECEASED _____</p>		<p>29. SIGNATURE OF DECEASED _____</p>		<p>30. SIGNATURE OF DECEASED _____</p>	
<p>31. SIGNATURE OF DECEASED _____</p>		<p>32. SIGNATURE OF DECEASED _____</p>		<p>33. SIGNATURE OF DECEASED _____</p>	
<p>34. SIGNATURE OF DECEASED _____</p>		<p>35. SIGNATURE OF DECEASED _____</p>		<p>36. SIGNATURE OF DECEASED _____</p>	
<p>37. SIGNATURE OF DECEASED _____</p>		<p>38. SIGNATURE OF DECEASED _____</p>		<p>39. SIGNATURE OF DECEASED _____</p>	
<p>40. SIGNATURE OF DECEASED _____</p>		<p>41. SIGNATURE OF DECEASED _____</p>		<p>42. SIGNATURE OF DECEASED _____</p>	
<p>43. SIGNATURE OF DECEASED _____</p>		<p>44. SIGNATURE OF DECEASED _____</p>		<p>45. SIGNATURE OF DECEASED _____</p>	
<p>46. SIGNATURE OF DECEASED _____</p>		<p>47. SIGNATURE OF DECEASED _____</p>		<p>48. SIGNATURE OF DECEASED _____</p>	
<p>49. SIGNATURE OF DECEASED _____</p>		<p>50. SIGNATURE OF DECEASED _____</p>		<p>51. SIGNATURE OF DECEASED _____</p>	
<p>52. SIGNATURE OF DECEASED _____</p>		<p>53. SIGNATURE OF DECEASED _____</p>		<p>54. SIGNATURE OF DECEASED _____</p>	
<p>55. SIGNATURE OF DECEASED _____</p>		<p>56. SIGNATURE OF DECEASED _____</p>		<p>57. SIGNATURE OF DECEASED _____</p>	
<p>58. SIGNATURE OF DECEASED _____</p>		<p>59. SIGNATURE OF DECEASED _____</p>		<p>60. SIGNATURE OF DECEASED _____</p>	
<p>61. SIGNATURE OF DECEASED _____</p>		<p>62. SIGNATURE OF DECEASED _____</p>		<p>63. SIGNATURE OF DECEASED _____</p>	
<p>64. SIGNATURE OF DECEASED _____</p>		<p>65. SIGNATURE OF DECEASED _____</p>		<p>66. SIGNATURE OF DECEASED _____</p>	
<p>67. SIGNATURE OF DECEASED _____</p>		<p>68. SIGNATURE OF DECEASED _____</p>		<p>69. SIGNATURE OF DECEASED _____</p>	
<p>70. SIGNATURE OF DECEASED _____</p>		<p>71. SIGNATURE OF DECEASED _____</p>		<p>72. SIGNATURE OF DECEASED _____</p>	
<p>73. SIGNATURE OF DECEASED _____</p>		<p>74. SIGNATURE OF DECEASED _____</p>		<p>75. SIGNATURE OF DECEASED _____</p>	
<p>76. SIGNATURE OF DECEASED _____</p>		<p>77. SIGNATURE OF DECEASED _____</p>		<p>78. SIGNATURE OF DECEASED _____</p>	
<p>79. SIGNATURE OF DECEASED _____</p>		<p>80. SIGNATURE OF DECEASED _____</p>		<p>81. SIGNATURE OF DECEASED _____</p>	
<p>82. SIGNATURE OF DECEASED _____</p>		<p>83. SIGNATURE OF DECEASED _____</p>		<p>84. SIGNATURE OF DECEASED _____</p>	
<p>85. SIGNATURE OF DECEASED _____</p>		<p>86. SIGNATURE OF DECEASED _____</p>		<p>87. SIGNATURE OF DECEASED _____</p>	
<p>88. SIGNATURE OF DECEASED _____</p>		<p>89. SIGNATURE OF DECEASED _____</p>		<p>90. SIGNATURE OF DECEASED _____</p>	
<p>91. SIGNATURE OF DECEASED _____</p>		<p>92. SIGNATURE OF DECEASED _____</p>		<p>93. SIGNATURE OF DECEASED _____</p>	
<p>94. SIGNATURE OF DECEASED _____</p>		<p>95. SIGNATURE OF DECEASED _____</p>		<p>96. SIGNATURE OF DECEASED _____</p>	
<p>97. SIGNATURE OF DECEASED _____</p>		<p>98. SIGNATURE OF DECEASED _____</p>		<p>99. SIGNATURE OF DECEASED _____</p>	
<p>100. SIGNATURE OF DECEASED _____</p>		<p>101. SIGNATURE OF DECEASED _____</p>		<p>102. SIGNATURE OF DECEASED _____</p>	

BUREAU V. 2

JAN 7 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12848

Reg. Dist. No.

12869

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>				c. LENGTH OF STAY IN 1b <u>1.6 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1320 - 55th Avenue</u>				d. STREET ADDRESS <u>1320 - 55th Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>William Albert Taylor</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1892</u>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-09-5236</u>			
17. INFORMANT <u>Mrs. Mary Taylor</u>				Address <u>same as #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec 27-56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>				22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros</u>				24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>			
ADDRESS <u>1661-94 Hager Rd SE</u>				24b. REGISTRAR'S SIGNATURE <u>H. Dedrick</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814

CERTIFICATE OF DEATH

Reg. Dist. No.

12849

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>				d. STREET ADDRESS <u>4536 Banner</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Lee Triplett</u>				4. DATE OF DEATH Month Day Year <u>December 19 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1898</u>		9. AGE (In years last birthday) yrs. <u>58</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yards</u>		11. BIRTHPLACE (State or foreign country) <u>Richardsville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Triplette</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Fields</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Warrenton Triplett Martin - 1537 Milton Ave. Balto., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271 Congestive heart failure</u> DUE TO (b) <u>Chronic pulmonary</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/9</u> , 19 <u>56</u> to <u>12/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>56</u> , and that death occurred at <u>12:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John Keloe</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles R. Law 802 Madison Avenue,</u>				24a. RECEIVED BY REGISTRAR <u>DEC 19 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. K. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John M. Smith		Male		White		June 15, 1908		Baltimore, Md.		June 15, 1956		Baltimore, Md.		Heart disease		Natural		J. M. Smith		J. M. Smith		June 15, 1956	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Country		19. Telephone		20. Hospital		21. Physician		22. Registrar		23. Date		24. Time	
John M. Smith		Son		1234 Main St.		Baltimore		Md.		U.S.A.		(410) 123-4567		St. Mary's		J. M. Smith		J. M. Smith		June 15, 1956		10:00 AM	
25. Name of informant		26. Relationship		27. Address		28. City		29. State		30. Country		31. Telephone		32. Hospital		33. Physician		34. Registrar		35. Date		36. Time	
John M. Smith		Son		1234 Main St.		Baltimore		Md.		U.S.A.		(410) 123-4567		St. Mary's		J. M. Smith		J. M. Smith		June 15, 1956		10:00 AM	

BUREAU V. 2

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12870

CERTIFICATE OF DEATH

12850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Princes Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4107 Shepherd Street				d. STREET ADDRESS 4107 Shepherd Street			
3. NAME OF DECEASED (Type or print) First William Middle C. Last Tyrea				4. DATE OF DEATH Month 12 Day 23 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1886	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Employment Agency				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Tyrea				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-342-419		17. INFORMANT Mrs. Gladys E. Tyrea-4107 Shepherd St. Cottage City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease (c) Emphysema				INTERVAL BETWEEN ONSET AND DEATH 12-23-56			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-18 , 19 56 , to 12-23 , 19 56 that I last saw the deceased alive on 12/23 , 19 56 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Hageage				M.D. 3717-3842 ADDRESS (Street, city or town, state) DATE SIGNED 12-23-56			
PHYSICIAN'S NAME (Type) George J. Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St. N.W.				24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE Carrin Campbell	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>DATE OF BIRTH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>DATE OF INTERMENT [Faint text]</p>		<p>PLACE OF INTERMENT [Faint text]</p>	
<p>NAME OF PHYSICIAN [Faint text]</p>		<p>NAME OF FUNERAL HOME [Faint text]</p>	
<p>NAME OF MINISTER [Faint text]</p>		<p>NAME OF BURIAL PLACE [Faint text]</p>	
<p>NAME OF CITY [Faint text]</p>		<p>NAME OF COUNTY [Faint text]</p>	
<p>NAME OF STATE [Faint text]</p>		<p>NAME OF COUNTRY [Faint text]</p>	

BUREAU V. S.

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815

CERTIFICATE OF DEATH

12851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Dev. Hosp.</u>				d. STREET ADDRESS <u>9735-53rd Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Walters</u>				4. DATE OF DEATH <u>Dec. 25, 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1956</u>	
9. AGE (In years last birthday) <u>3</u>		IF UNDER 1 YEAR <u>3</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Mid</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Walters, Raymond S.</u>				14. MOTHER'S MAIDEN NAME <u>Norwathy, Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital - Chesley, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/25, 1956</u> , to <u>12/25, 1956</u> , that I last saw the deceased alive on <u>12/25, 1956</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DEC 31 '56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2077335XV0

CERTIFICATE OF DEATH

1. NAME OF DECEASED LAST, FIRST, MIDDLE _____		2. SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
3. AGE YEARS _____ MONTHS _____		4. DATE OF BIRTH MONTH _____ DAY _____ YEAR _____	
5. PLACE OF BIRTH _____		6. PLACE OF DEATH _____	
7. OCCUPATION _____		8. CAUSE OF DEATH _____	
9. MANNER OF DEATH NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		10. DATE OF DEATH MONTH _____ DAY _____ YEAR _____	
11. SIGNATURE OF PHYSICIAN _____		12. SIGNATURE OF DEATH REGISTRAR _____	
13. SIGNATURE OF WITNESS _____		14. SIGNATURE OF WITNESS _____	
15. SIGNATURE OF WITNESS _____		16. SIGNATURE OF WITNESS _____	
17. SIGNATURE OF WITNESS _____		18. SIGNATURE OF WITNESS _____	
19. SIGNATURE OF WITNESS _____		20. SIGNATURE OF WITNESS _____	
21. SIGNATURE OF WITNESS _____		22. SIGNATURE OF WITNESS _____	
23. SIGNATURE OF WITNESS _____		24. SIGNATURE OF WITNESS _____	
25. SIGNATURE OF WITNESS _____		26. SIGNATURE OF WITNESS _____	
27. SIGNATURE OF WITNESS _____		28. SIGNATURE OF WITNESS _____	
29. SIGNATURE OF WITNESS _____		30. SIGNATURE OF WITNESS _____	
31. SIGNATURE OF WITNESS _____		32. SIGNATURE OF WITNESS _____	
33. SIGNATURE OF WITNESS _____		34. SIGNATURE OF WITNESS _____	
35. SIGNATURE OF WITNESS _____		36. SIGNATURE OF WITNESS _____	
37. SIGNATURE OF WITNESS _____		38. SIGNATURE OF WITNESS _____	
39. SIGNATURE OF WITNESS _____		40. SIGNATURE OF WITNESS _____	
41. SIGNATURE OF WITNESS _____		42. SIGNATURE OF WITNESS _____	
43. SIGNATURE OF WITNESS _____		44. SIGNATURE OF WITNESS _____	
45. SIGNATURE OF WITNESS _____		46. SIGNATURE OF WITNESS _____	
47. SIGNATURE OF WITNESS _____		48. SIGNATURE OF WITNESS _____	
49. SIGNATURE OF WITNESS _____		50. SIGNATURE OF WITNESS _____	
51. SIGNATURE OF WITNESS _____		52. SIGNATURE OF WITNESS _____	
53. SIGNATURE OF WITNESS _____		54. SIGNATURE OF WITNESS _____	
55. SIGNATURE OF WITNESS _____		56. SIGNATURE OF WITNESS _____	
57. SIGNATURE OF WITNESS _____		58. SIGNATURE OF WITNESS _____	
59. SIGNATURE OF WITNESS _____		60. SIGNATURE OF WITNESS _____	
61. SIGNATURE OF WITNESS _____		62. SIGNATURE OF WITNESS _____	
63. SIGNATURE OF WITNESS _____		64. SIGNATURE OF WITNESS _____	
65. SIGNATURE OF WITNESS _____		66. SIGNATURE OF WITNESS _____	
67. SIGNATURE OF WITNESS _____		68. SIGNATURE OF WITNESS _____	
69. SIGNATURE OF WITNESS _____		70. SIGNATURE OF WITNESS _____	
71. SIGNATURE OF WITNESS _____		72. SIGNATURE OF WITNESS _____	
73. SIGNATURE OF WITNESS _____		74. SIGNATURE OF WITNESS _____	
75. SIGNATURE OF WITNESS _____		76. SIGNATURE OF WITNESS _____	
77. SIGNATURE OF WITNESS _____		78. SIGNATURE OF WITNESS _____	
79. SIGNATURE OF WITNESS _____		80. SIGNATURE OF WITNESS _____	
81. SIGNATURE OF WITNESS _____		82. SIGNATURE OF WITNESS _____	
83. SIGNATURE OF WITNESS _____		84. SIGNATURE OF WITNESS _____	
85. SIGNATURE OF WITNESS _____		86. SIGNATURE OF WITNESS _____	
87. SIGNATURE OF WITNESS _____		88. SIGNATURE OF WITNESS _____	
89. SIGNATURE OF WITNESS _____		90. SIGNATURE OF WITNESS _____	
91. SIGNATURE OF WITNESS _____		92. SIGNATURE OF WITNESS _____	
93. SIGNATURE OF WITNESS _____		94. SIGNATURE OF WITNESS _____	
95. SIGNATURE OF WITNESS _____		96. SIGNATURE OF WITNESS _____	
97. SIGNATURE OF WITNESS _____		98. SIGNATURE OF WITNESS _____	
99. SIGNATURE OF WITNESS _____		100. SIGNATURE OF WITNESS _____	

RECEIVED

DEC 14 1950

BUREAU

CERTIFICATE OF DEATH

12852

Reg. Dist. No.

12871

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 23</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SVITLAND NURSING HOME</u>		d. STREET ADDRESS <u>4010 Livingston Rd. P.C.</u>	
3. NAME OF DECEASED (Type or print) First <u>ISABEL</u> Middle <u>P.</u> Last <u>WATKINS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18 1875</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN PENMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN PETTIGREW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. MAE CUMMINGS</u>		Address <u>4010 LIVINGSTON RD. S.E. WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>1 YR.</u> <u>10 YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 6, 1956</u> to <u>Dec. 13, 1956</u> , that I last saw the deceased alive on <u>Dec. 12, 1956</u> , and that death occurred at <u>1200</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank S. Pellegrini</u> M.D.		ADDRESS (Street, city or town, state) <u>3409 ACAB AVE SE</u> DATE SIGNED <u>12.13.56</u>	
PHYSICIAN'S NAME (Type) <u>FRANK S. PELLEGRINI</u>		<u>WASH 20 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-13-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Fun Home</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wash. Fun Home</u>		24a. REC'D BY REGISTRAR <u>DEC 17 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE

TO BE FILLED BY THE REGISTRAR

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

GENERALIZED ARTERIO-SCLEROSIS
ARTERIO-SCLEROSIS HEART DISEASE
CORONARY HEART FAILURE

BUREAU V. E.

DEC 17 1956

RECEIVED

Franklin D. Roosevelt
Dec 12 1956

James J. Davis
Dec 12 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12853

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Dead on arrival			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vedder Middle Folk Last Watson				4. DATE OF DEATH Month December Day 28 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Yard		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Watson				14. MOTHER'S MAIDEN NAME Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW11		17. INFORMANT Imogene Watson, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED December 28, 1956			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee's Sons Co. 300 4th St				24a. REC'D BY REGISTRAR DATE 12-31-56		24b. REGISTRAR'S SIGNATURE Carrie F. Campbell	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
January 1, 1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Farmer	
Signature of Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JAN 4 1957

RECEIVED

TO BE RELIED UPON BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12872

Item 1, Film G209, 1/1/57 fcy **CERTIFICATE OF DEATH**

Reg. Dist. No.

12854

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights,				c. LENGTH OF STAY IN 1b 1-DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5103-26 AVE HILLCREST HTS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES H. Middle WEBER Last WEBER				4. DATE OF DEATH Month Dec Day 30 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 23 1891	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REC'DR NAVY YARD		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ENTILE OTTO WEBER				14. MOTHER'S MAIDEN NAME ANNIE SCHMIT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. NO		17. INFORMANT MARGARET WEBER			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Ca DUE TO (c) Ca rectum				INTERVAL BETWEEN ONSET AND DEATH 2 mos 6 " 3			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov , 1956, to Dec 30 , 1956, that I last saw the deceased alive on Dec 29 , 1956, and that death occurred at 5:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jeannette Bateman M.D.				ADDRESS (Street, city or town, state) R ST NW			
PHYSICIAN'S NAME (Type) Jeannette Bateman				DATE SIGNED Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
		1-2-57		Cedar Hill		Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Lee's Sons				ADDRESS 300-4 ST NE DC		24a. REC'D BY REGISTRAR DATE 12-1-56	
				24b. REGISTRAR'S SIGNATURE W. H. Smith			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. PLACE OF INTERMENT		18. DATE OF INTERMENT		19. TIME OF INTERMENT		20. CAUSE OF INTERMENT		21. MANNER OF INTERMENT		22. SIGNATURE OF PHYSICIAN		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF WITNESSES	
25. PLACE OF BURIAL		26. DATE OF BURIAL		27. TIME OF BURIAL		28. CAUSE OF BURIAL		29. MANNER OF BURIAL		30. SIGNATURE OF PHYSICIAN		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF WITNESSES	
33. PLACE OF CREMATION		34. DATE OF CREMATION		35. TIME OF CREMATION		36. CAUSE OF CREMATION		37. MANNER OF CREMATION		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF WITNESSES	
41. PLACE OF EXHUMATION		42. DATE OF EXHUMATION		43. TIME OF EXHUMATION		44. CAUSE OF EXHUMATION		45. MANNER OF EXHUMATION		46. SIGNATURE OF PHYSICIAN		47. SIGNATURE OF REGISTRAR		48. SIGNATURE OF WITNESSES	
49. PLACE OF REINTERMENT		50. DATE OF REINTERMENT		51. TIME OF REINTERMENT		52. CAUSE OF REINTERMENT		53. MANNER OF REINTERMENT		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR		56. SIGNATURE OF WITNESSES	
57. PLACE OF REBURYAL		58. DATE OF REBURYAL		59. TIME OF REBURYAL		60. CAUSE OF REBURYAL		61. MANNER OF REBURYAL		62. SIGNATURE OF PHYSICIAN		63. SIGNATURE OF REGISTRAR		64. SIGNATURE OF WITNESSES	
65. PLACE OF RECREMATION		66. DATE OF RECREMATION		67. TIME OF RECREMATION		68. CAUSE OF RECREMATION		69. MANNER OF RECREMATION		70. SIGNATURE OF PHYSICIAN		71. SIGNATURE OF REGISTRAR		72. SIGNATURE OF WITNESSES	
73. PLACE OF REEXHUMATION		74. DATE OF REEXHUMATION		75. TIME OF REEXHUMATION		76. CAUSE OF REEXHUMATION		77. MANNER OF REEXHUMATION		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF REGISTRAR		80. SIGNATURE OF WITNESSES	
81. PLACE OF REINTERMENT		82. DATE OF REINTERMENT		83. TIME OF REINTERMENT		84. CAUSE OF REINTERMENT		85. MANNER OF REINTERMENT		86. SIGNATURE OF PHYSICIAN		87. SIGNATURE OF REGISTRAR		88. SIGNATURE OF WITNESSES	
89. PLACE OF REBURYAL		90. DATE OF REBURYAL		91. TIME OF REBURYAL		92. CAUSE OF REBURYAL		93. MANNER OF REBURYAL		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR		96. SIGNATURE OF WITNESSES	
97. PLACE OF RECREMATION		98. DATE OF RECREMATION		99. TIME OF RECREMATION		100. CAUSE OF RECREMATION		101. MANNER OF RECREMATION		102. SIGNATURE OF PHYSICIAN		103. SIGNATURE OF REGISTRAR		104. SIGNATURE OF WITNESSES	
105. PLACE OF REEXHUMATION		106. DATE OF REEXHUMATION		107. TIME OF REEXHUMATION		108. CAUSE OF REEXHUMATION		109. MANNER OF REEXHUMATION		110. SIGNATURE OF PHYSICIAN		111. SIGNATURE OF REGISTRAR		112. SIGNATURE OF WITNESSES	
113. PLACE OF REINTERMENT		114. DATE OF REINTERMENT		115. TIME OF REINTERMENT		116. CAUSE OF REINTERMENT		117. MANNER OF REINTERMENT		118. SIGNATURE OF PHYSICIAN		119. SIGNATURE OF REGISTRAR		120. SIGNATURE OF WITNESSES	
121. PLACE OF REBURYAL		122. DATE OF REBURYAL		123. TIME OF REBURYAL		124. CAUSE OF REBURYAL		125. MANNER OF REBURYAL		126. SIGNATURE OF PHYSICIAN		127. SIGNATURE OF REGISTRAR		128. SIGNATURE OF WITNESSES	
129. PLACE OF RECREMATION		130. DATE OF RECREMATION		131. TIME OF RECREMATION		132. CAUSE OF RECREMATION		133. MANNER OF RECREMATION		134. SIGNATURE OF PHYSICIAN		135. SIGNATURE OF REGISTRAR		136. SIGNATURE OF WITNESSES	
137. PLACE OF REEXHUMATION		138. DATE OF REEXHUMATION		139. TIME OF REEXHUMATION		140. CAUSE OF REEXHUMATION		141. MANNER OF REEXHUMATION		142. SIGNATURE OF PHYSICIAN		143. SIGNATURE OF REGISTRAR		144. SIGNATURE OF WITNESSES	
145. PLACE OF REINTERMENT		146. DATE OF REINTERMENT		147. TIME OF REINTERMENT		148. CAUSE OF REINTERMENT		149. MANNER OF REINTERMENT		150. SIGNATURE OF PHYSICIAN		151. SIGNATURE OF REGISTRAR		152. SIGNATURE OF WITNESSES	
153. PLACE OF REBURYAL		154. DATE OF REBURYAL		155. TIME OF REBURYAL		156. CAUSE OF REBURYAL		157. MANNER OF REBURYAL		158. SIGNATURE OF PHYSICIAN		159. SIGNATURE OF REGISTRAR		160. SIGNATURE OF WITNESSES	
161. PLACE OF RECREMATION		162. DATE OF RECREMATION		163. TIME OF RECREMATION		164. CAUSE OF RECREMATION		165. MANNER OF RECREMATION		166. SIGNATURE OF PHYSICIAN		167. SIGNATURE OF REGISTRAR		168. SIGNATURE OF WITNESSES	
169. PLACE OF REEXHUMATION		170. DATE OF REEXHUMATION		171. TIME OF REEXHUMATION		172. CAUSE OF REEXHUMATION		173. MANNER OF REEXHUMATION		174. SIGNATURE OF PHYSICIAN		175. SIGNATURE OF REGISTRAR		176. SIGNATURE OF WITNESSES	
177. PLACE OF REINTERMENT		178. DATE OF REINTERMENT		179. TIME OF REINTERMENT		180. CAUSE OF REINTERMENT		181. MANNER OF REINTERMENT		182. SIGNATURE OF PHYSICIAN		183. SIGNATURE OF REGISTRAR		184. SIGNATURE OF WITNESSES	
185. PLACE OF REBURYAL		186. DATE OF REBURYAL		187. TIME OF REBURYAL		188. CAUSE OF REBURYAL		189. MANNER OF REBURYAL		190. SIGNATURE OF PHYSICIAN		191. SIGNATURE OF REGISTRAR		192. SIGNATURE OF WITNESSES	
193. PLACE OF RECREMATION		194. DATE OF RECREMATION		195. TIME OF RECREMATION		196. CAUSE OF RECREMATION		197. MANNER OF RECREMATION		198. SIGNATURE OF PHYSICIAN		199. SIGNATURE OF REGISTRAR		200. SIGNATURE OF WITNESSES	
201. PLACE OF REEXHUMATION		202. DATE OF REEXHUMATION		203. TIME OF REEXHUMATION		204. CAUSE OF REEXHUMATION		205. MANNER OF REEXHUMATION		206. SIGNATURE OF PHYSICIAN		207. SIGNATURE OF REGISTRAR		208. SIGNATURE OF WITNESSES	
209. PLACE OF REINTERMENT		210. DATE OF REINTERMENT		211. TIME OF REINTERMENT		212. CAUSE OF REINTERMENT		213. MANNER OF REINTERMENT		214. SIGNATURE OF PHYSICIAN		215. SIGNATURE OF REGISTRAR		216. SIGNATURE OF WITNESSES	
217. PLACE OF REBURYAL		218. DATE OF REBURYAL		219. TIME OF REBURYAL		220. CAUSE OF REBURYAL		221. MANNER OF REBURYAL		222. SIGNATURE OF PHYSICIAN		223. SIGNATURE OF REGISTRAR		224. SIGNATURE OF WITNESSES	
225. PLACE OF RECREMATION		226. DATE OF RECREMATION		227. TIME OF RECREMATION		228. CAUSE OF RECREMATION		229. MANNER OF RECREMATION		230. SIGNATURE OF PHYSICIAN		231. SIGNATURE OF REGISTRAR		232. SIGNATURE OF WITNESSES	
233. PLACE OF REEXHUMATION		234. DATE OF REEXHUMATION		235. TIME OF REEXHUMATION		236. CAUSE OF REEXHUMATION		237. MANNER OF REEXHUMATION		238. SIGNATURE OF PHYSICIAN		239. SIGNATURE OF REGISTRAR		240. SIGNATURE OF WITNESSES	
241. PLACE OF REINTERMENT		242. DATE OF REINTERMENT		243. TIME OF REINTERMENT		244. CAUSE OF REINTERMENT		245. MANNER OF REINTERMENT		246. SIGNATURE OF PHYSICIAN		247. SIGNATURE OF REGISTRAR		248. SIGNATURE OF WITNESSES	
249. PLACE OF REBURYAL		250. DATE OF REBURYAL		251. TIME OF REBURYAL		252. CAUSE OF REBURYAL		253. MANNER OF REBURYAL		254. SIGNATURE OF PHYSICIAN		255. SIGNATURE OF REGISTRAR		256. SIGNATURE OF WITNESSES	
257. PLACE OF RECREMATION		258. DATE OF RECREMATION		259. TIME OF RECREMATION		260. CAUSE OF RECREMATION		261. MANNER OF RECREMATION		262. SIGNATURE OF PHYSICIAN		263. SIGNATURE OF REGISTRAR		264. SIGNATURE OF WITNESSES	
265. PLACE OF REEXHUMATION		266. DATE OF REEXHUMATION		267. TIME OF REEXHUMATION		268. CAUSE OF REEXHUMATION		269. MANNER OF REEXHUMATION		270. SIGNATURE OF PHYSICIAN		271. SIGNATURE OF REGISTRAR		272. SIGNATURE OF WITNESSES	
273. PLACE OF REINTERMENT		274. DATE OF REINTERMENT		275. TIME OF REINTERMENT		276. CAUSE OF REINTERMENT		277. MANNER OF REINTERMENT		278. SIGNATURE OF PHYSICIAN		279. SIGNATURE OF REGISTRAR		280. SIGNATURE OF WITNESSES	
281. PLACE OF REBURYAL		282. DATE OF REBURYAL		283. TIME OF REBURYAL		284. CAUSE OF REBURYAL		285. MANNER OF REBURYAL		286. SIGNATURE OF PHYSICIAN		287. SIGNATURE OF REGISTRAR		288. SIGNATURE OF WITNESSES	
289. PLACE OF RECREMATION		290. DATE OF RECREMATION		291. TIME OF RECREMATION		292. CAUSE OF RECREMATION		293. MANNER OF RECREMATION		294. SIGNATURE OF PHYSICIAN		295. SIGNATURE OF REGISTRAR		296. SIGNATURE OF WITNESSES	
297. PLACE OF REEXHUMATION		298. DATE OF REEXHUMATION		299. TIME OF REEXHUMATION		300. CAUSE OF REEXHUMATION		301. MANNER OF REEXHUMATION		302. SIGNATURE OF PHYSICIAN		303. SIGNATURE OF REGISTRAR		304. SIGNATURE OF WITNESSES	
305. PLACE OF REINTERMENT		306. DATE OF REINTERMENT		307. TIME OF REINTERMENT		308. CAUSE OF REINTERMENT		309. MANNER OF REINTERMENT		310. SIGNATURE OF PHYSICIAN		311. SIGNATURE OF REGISTRAR		312. SIGNATURE OF WITNESSES	
313. PLACE OF REBURYAL		314. DATE OF REBURYAL		315. TIME OF REBURYAL		316. CAUSE OF REBURYAL		317. MANNER OF REBURYAL		318. SIGNATURE OF PHYSICIAN		319. SIGNATURE OF REGISTRAR		320. SIGNATURE OF WITNESSES	
321. PLACE OF RECREMATION		322. DATE OF RECREMATION		323. TIME OF RECREMATION		324. CAUSE OF RECREMATION		325. MANNER OF RECREMATION		326. SIGNATURE OF PHYSICIAN		327. SIGNATURE OF REGISTRAR		328. SIGNATURE OF WITNESSES	
329. PLACE OF REEXHUMATION		330. DATE OF REEXHUMATION		331. TIME OF REEXHUMATION		332. CAUSE OF REEXHUMATION		333. MANNER OF REEXHUMATION		334. SIGNATURE OF PHYSICIAN		335. SIGNATURE OF REGISTRAR		336. SIGNATURE OF WITNESSES	
337. PLACE OF REINTERMENT		338. DATE OF REINTERMENT		339. TIME OF REINTERMENT		340. CAUSE OF REINTERMENT		341. MANNER OF REINTERMENT		342. SIGNATURE OF PHYSICIAN		343. SIGNATURE OF REGISTRAR		344. SIGNATURE OF WITNESSES	
345. PLACE OF REBURYAL		346. DATE OF REBURYAL		347. TIME OF REBURYAL		348. CAUSE OF REBURYAL		349. MANNER OF REBURYAL		350. SIGNATURE OF PHYSICIAN		351. SIGNATURE OF REGISTRAR		352. SIGNATURE OF WITNESSES	
353. PLACE OF RECREMATION		354. DATE OF RECREMATION		355. TIME OF RECREMATION		356. CAUSE OF RECREMATION		357. MANNER OF RECREMATION		358. SIGNATURE OF PHYSICIAN		359. SIGNATURE OF REGISTRAR		360. SIGNATURE OF WITNESSES	
361. PLACE OF REEXHUMATION		362. DATE OF REEXHUMATION		363. TIME OF REEXHUMATION		364. CAUSE OF REEXHUMATION		365. MANNER OF REEXHUMATION		366. SIGNATURE OF PHYSICIAN		367. SIGNATURE OF REGISTRAR		368. SIGNATURE OF WITNESSES	
369. PLACE OF REINTERMENT		370. DATE OF REINTERMENT		371. TIME OF REINTERMENT		372. CAUSE OF REINTERMENT		373. MANNER OF REINTERMENT		374. SIGNATURE OF PHYSICIAN		375. SIGNATURE OF REGISTRAR		376. SIGNATURE OF WITNESSES	
377. PLACE OF REBURYAL		378. DATE OF REBURYAL		379. TIME OF REBURYAL		380. CAUSE OF REBURYAL		381. MANNER OF REBURYAL		382. SIGNATURE OF PHYSICIAN		383. SIGNATURE OF REGISTRAR		384. SIGNATURE OF WITNESSES	
385. PLACE OF RECREMATION		386. DATE OF RECREMATION		387. TIME OF RECREMATION		388. CAUSE OF RECREMATION		389. MANNER OF RECREMATION		390. SIGNATURE OF PHYSICIAN		391. SIGNATURE OF REGISTRAR		392. SIGNATURE OF WITNESSES	
393. PLACE OF REEXHUMATION		394. DATE OF REEXHUMATION		395. TIME OF REEXHUMATION		396. CAUSE OF REEXHUMATION		397. MANNER OF REEXHUMATION		398. SIGNATURE OF PHYSICIAN		399. SIGNATURE OF REGISTRAR		400. SIGNATURE OF WITNESSES	
401. PLACE OF REINTERMENT		402. DATE OF REINTERMENT		403. TIME OF REINTERMENT		404. CAUSE OF REINTERMENT		405. MANNER OF REINTERMENT		406. SIGNATURE OF PHYSICIAN		407. SIGNATURE OF REGISTRAR		408. SIGNATURE OF WITNESSES	
409. PLACE OF REBURYAL		410. DATE OF REBURYAL		411. TIME OF REBURYAL		412. CAUSE OF REBURYAL		413. MANNER OF REBURYAL		414. SIGNATURE OF PHYSICIAN		415. SIGNATURE OF REGISTRAR		416. SIGNATURE OF WITNESSES	
417. PLACE OF RECREMATION		418. DATE OF RECREMATION		419. TIME OF RECREMATION		420. CAUSE OF RECREMATION		421. MANNER OF RECREMATION		422. SIGNATURE OF PHYSICIAN		423. SIGNATURE OF REGISTRAR		424. SIGNATURE OF WITNESSES	
425. PLACE OF REEXHUMATION		426. DATE OF REEXHUMATION		427. TIME OF REEXHUMATION		428. CAUSE OF REEXHUMATION		429. MANNER OF REEXHUMATION		430. SIGNATURE OF PHYSICIAN		431. SIGNATURE OF REGISTRAR		432. SIGNATURE OF WITNESSES	
433. PLACE OF REINTERMENT		434. DATE OF REINTERMENT		435. TIME OF REINTERMENT		436. CAUSE OF REINTERMENT		437. MANNER OF REINTERMENT		438. SIGNATURE OF PHYSICIAN		439. SIGNATURE OF REGISTRAR		440. SIGNATURE OF WITNESSES	
441. PLACE OF REBURYAL		442. DATE OF REBURYAL		443. TIME OF REBURYAL		444. CAUSE OF REBURYAL		445. MANNER OF REBURYAL		446. SIGNATURE OF PHYSICIAN		447. SIGNATURE OF REGISTRAR		448. SIGNATURE OF WITNESSES	
449. PLACE OF RECREMATION		450. DATE OF RECREMATION		451. TIME OF RECREMATION		452. CAUSE OF RECREMATION		453. MANNER OF RECREMATION		454. SIGNATURE OF PHYSICIAN		455. SIGNATURE OF REGISTRAR		456. SIGNATURE OF WITNESSES	
457. PLACE OF REEXHUMATION		458. DATE OF REEXHUMATION		459. TIME OF REEXHUMATION		460. CAUSE OF REEXHUMATION		461. MANNER OF REEXHUMATION		462. SIGNATURE OF PHYSICIAN		463. SIGNATURE OF REGISTRAR		464. SIGNATURE OF WITNESSES	
465. PLACE OF REINTERMENT		466. DATE OF REINTERMENT		467. TIME OF REINTERMENT		468. CAUSE OF REINTERMENT		469. MANNER OF REINTERMENT		470. SIGNATURE OF PHYSICIAN		471. SIGNATURE OF REGISTRAR		472. SIGNATURE OF WITNESSES	
473. PLACE OF REBURYAL		474. DATE OF REBURYAL		475. TIME OF REBURYAL		476. CAUSE OF REBURYAL		477. MANNER OF REBURYAL		478. SIGNATURE OF PHYSICIAN		479. SIGNATURE OF REGISTRAR		480. SIGNATURE OF WITNESSES	
481. PLACE OF RECREMATION		482. DATE OF RECREMATION		483. TIME OF RECREMATION		484. CAUSE OF RECREMATION		485. MANNER OF RECREMATION		486. SIGNATURE OF PHYSICIAN		487. SIGNATURE OF REGISTRAR		488. SIGNATURE OF WITNESSES	
489. PLACE OF REEXHUMATION		490. DATE OF REEXHUMATION		491. TIME OF REEXHUMATION		492. CAUSE OF REEXHUMATION		493. MANNER OF REEXHUMATION		494. SIGNATURE OF PHYSICIAN		495. SIGNATURE OF REGISTRAR		496. SIGNATURE OF WITNESSES	
497. PLACE OF REINTERMENT		498. DATE OF REINTERMENT		499. TIME OF REINTERMENT		500. CAUSE OF REINTERMENT		501. MANNER OF REINTERMENT		502. SIGNATURE OF PHYSICIAN		503. SIGNATURE OF REGISTRAR		504. SIGNATURE OF WITNESSES	
505. PLACE OF REBURYAL		506. DATE OF REBURYAL		507. TIME OF REBURYAL		508. CAUSE OF REBURYAL		509. MANNER OF REBURYAL		510. SIGNATURE OF PHYSICIAN		511. SIGNATURE OF REGISTRAR		512. SIGNATURE OF WITNESSES	
513. PLACE OF RECREMATION		514. DATE OF RECREMATION		515. TIME OF RECREMATION		516. CAUSE OF RECREMATION		517. MANNER OF RECREMATION		518. SIGNATURE OF PHYSICIAN		519. SIGNATURE OF REGISTRAR		520. SIGNATURE OF WITNESSES	
521. PLACE OF REEXHUMATION		522. DATE OF REEXHUMATION		523. TIME OF REEXHUMATION		524. CAUSE OF REEXHUMATION		525. MANNER OF REEXHUMATION		526. SIGNATURE OF PHYSICIAN		527. SIGNATURE OF REGISTRAR		528. SIGNATURE OF WITNESSES	
529. PLACE OF REINTERMENT		530. DATE OF REINTERMENT		531. TIME OF REINTERMENT		532. CAUSE OF REINTERMENT		533. MANNER OF REINTERMENT		534. SIGNATURE OF PHYSICIAN		535. SIGNATURE OF REGISTRAR		536. SIGNATURE OF WITNESSES	
537. PLACE OF REBURYAL		538. DATE OF REBURYAL		539. TIME OF REBURYAL		540. CAUSE OF REBURYAL		541. MANNER OF REBURYAL		542. SIGNATURE OF PHYSICIAN		543. SIGNATURE OF REGISTRAR		544. SIGNATURE OF WITNESSES	
545. PLACE OF RECREMATION		546. DATE OF RECREMATION		547. TIME OF RECREMATION		548. CAUSE OF RECREMATION		549. MANNER OF RECREMATION		550. SIGNATURE OF PHYSICIAN		551. SIGNATURE OF REGISTRAR		552. SIGNATURE OF WITNESSES	
553. PLACE OF REEXHUMATION		554. DATE OF REEXHUMATION		555. TIME OF REEXHUMATION		556. CAUSE OF REEXHUMATION		557. MANNER OF REEXHUMATION		558. SIGNATURE OF PHYSICIAN		559. SIGNATURE OF REGISTRAR		560. SIGNATURE OF WITNESSES	
561. PLACE OF REINTERMENT		562. DATE OF REINTERMENT		563. TIME OF REINTERMENT		564. CAUSE OF REINTERMENT		565. MANNER OF REINTERMENT		566. SIGNATURE OF PHYSICIAN		567. SIGNATURE OF REGISTRAR		568. SIGNATURE OF WITNESSES	
569. PLACE OF REBURYAL		570. DATE OF REBURYAL		571. TIME OF REBURYAL		572. CAUSE OF REBURYAL		573. MANNER OF REBURYAL		574. SIGNATURE OF PHYSICIAN		575. SIGNATURE OF REGISTRAR		576. SIGNATURE OF WITNESSES	
577. PLACE OF RECREMATION		578. DATE OF RECREMATION		579. TIME OF RECREMATION		580. CAUSE OF RECREMATION		581. MANNER OF RECREMATION		582. SIGNATURE OF PHYSICIAN		583. SIGNATURE OF REGISTRAR		584. SIGNATURE OF WITNESSES	
585. PLACE OF REEXHUMATION		586. DATE OF REEXHUMATION		587. TIME OF REEXHUMATION		588. CAUSE OF REEXHUMATION		589. MANNER OF REEXHUMATION		590. SIGNATURE OF PHYSICIAN		591. SIGNATURE OF REGISTRAR		592. SIGNATURE OF WITNESSES	
593. PLACE OF REINTERMENT		594. DATE OF REINTERMENT		595. TIME OF REINTERMENT		596. CAUSE OF REINTERMENT		597. MANNER OF REINTERMENT		598. SIGNATURE OF PHYSICIAN		599. SIGNATURE OF REGISTRAR		600. SIGNATURE OF WITNESSES	
601. PLACE OF REBURYAL		602. DATE OF REBURYAL		603. TIME OF REBURYAL		604. CAUSE OF REBURYAL		605. MANNER OF REBURYAL		606. SIGNATURE OF PHYSICIAN		607. SIGNATURE OF REGISTRAR		608. SIGNATURE OF WITNESSES	
609. PLACE OF RECREMATION		610. DATE OF RECREMATION		611. TIME OF RECREMATION		612. CAUSE OF RECREMATION		613. MANNER OF RECREMATION		614. SIGNATURE OF PHYSICIAN		615. SIGNATURE OF REGISTRAR		616. SIGNATURE OF WITNESSES	
617. PLACE OF REEXHUMATION		618. DATE OF REEXHUMATION</													

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12817

CERTIFICATE OF DEATH

Reg. Dist. No. 12855

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Geor.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Hill, Md.</i>				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.				d. STREET ADDRESS 1120 - 57th Ave.			
3. NAME OF DECEASED (Type or print) August Conrad Werner				4. DATE OF DEATH December 11, 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber (rtd)				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME August F. Werner				14. MOTHER'S MAIDEN NAME Fredericka -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marian W. Schmitz - 1017 E. Balto. St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Anteroventricular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 years 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 1, 1955, to Aug 11, 1956, that I last saw the deceased alive on December 11, 1956, and that death occurred at 12:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin				M.D. 6124 Central Ave 12/11/56			
PHYSICIAN'S NAME (Type) WM BRAININ				Capitol Hyge Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
ADDRESS 2500 Rockledge Ave				DATE 12/11/56		DEC 12 1956	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH (State and County)		PLACE OF DEATH (State and County)	
DATE OF BIRTH (Month, Day, Year)		DATE OF DEATH (Month, Day, Year)	
SEX Male Female		RACE White Negro Other	
MARITAL STATUS Single Married Widowed Divorced		OCCUPATION (Specify)	
US BIRTH RECORD NO. (If known)		MANNER OF DEATH (Specify)	
CAUSE OF DEATH (Specify)		MEDICAL HISTORY (Specify)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (Specify)	
SIGNATURE OF PHYSICIAN (Specify)		SIGNATURE OF CORONER (Specify)	
SIGNATURE OF JUDGE (Specify)		SIGNATURE OF CLERK (Specify)	

BUREAU V. E.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12856

12818

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wetland Memorial Hosp.</u>				d. STREET ADDRESS <u>6113-43rd Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>S.</u> Last <u>Westman</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/1886</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bureau of Engineering Penna.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hosp. records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>15 DAYS</u> <u>15 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBROVASCULAR ACCIDENT</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11 DEC., 1956</u> , to <u>26 DEC., 1956</u> , that I last saw the deceased alive on <u>26 DEC., 1956</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Hommann</u> M.D. <u>Riverdale Md</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>C. J. Hommann</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guscha Sons</u> ADDRESS <u>Hyattsville Md</u>				24a. REC'D BY REGISTRAR <u>JAN 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Avery</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON ONE 18

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>JAN 1 1967</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>MASSACHUSETTS</i>	
10. OCCUPATION <i>CLERK</i>		11. MARITAL STATUS <i>MARRIED</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF WITNESS <i>[Signature]</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		15. SIGNATURE OF REGISTRAR <i>[Signature]</i>	

RECEIVED
JAN 2 1967
BUREAU V. 1

CERTIFICATE OF DEATH

12819

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND CITY OR TOWN <u>LAUREL</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LAUREL SANITARIUM</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>P.G.</u> CITY OR TOWN <u>NORTH FORRESTVILLE</u> STREET ADDRESS <u>8002 MARION ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>BLANCHE (MMA) WHITE</u>				4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug. 31, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treasury Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bushrod Reed</u>				14. MOTHER'S MARDEN NAME <u>MARGARET BRANE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Daughter Mrs. B. Forkhurst - SAME Address</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - General</u>						<u>Several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes</u>						<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7:21</u> , 19 <u>56</u> , to <u>DEC 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>DEC 1</u> , 19 <u>56</u> , and that death occurred at <u>7:21</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Jesse C. Cragnis</u> M.D.				ADDRESS (Street, city, town, state) <u>Laurel Maryland</u> DATE SIGNED <u>12/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem</u>		LOCATION (City, town, or county) (State) <u>Cocke Manor Rd. Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mollie Bruchberg</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Charleston Co. Wash. D.C.</u>		ADDRESS <u>Md.</u>	
DATE <u>DEC 4 1956</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form 100-1

For use in reporting deaths occurring in the State of Maryland

1956

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH

EDUCATION
 OCCUPATION

NO. OF CHILDREN
 NO. OF SIBLINGS

DATE OF MARRIAGE
 NAME OF SPOUSE

DATE OF ENTRY INTO STATE
 PLACE OF ENTRY

DATE OF DEPARTURE FROM STATE
 PLACE OF DEPARTURE

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH

EDUCATION
 OCCUPATION

NO. OF CHILDREN
 NO. OF SIBLINGS

DATE OF MARRIAGE
 NAME OF SPOUSE

DATE OF ENTRY INTO STATE
 PLACE OF ENTRY

DATE OF DEPARTURE FROM STATE
 PLACE OF DEPARTURE

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

ENCLOSURE

JANUARY 1956

BUREAU V. 2

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12873

CERTIFICATE OF DEATH

12858

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>SAME</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>911 MAPLE AVE</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA</u> <u>IZORA</u> <u>WILDMAN</u>				4. DATE OF DEATH Month Day Year <u>DEC</u> <u>21</u> <u>1956</u>			
5. SEX <u>FE</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 12, 1896</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BOWIE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM WARREN PHELPS</u>				14. MOTHER'S MAIDEN NAME <u>CAPITOLA JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>WILLIAM WILDMAN-918 MAPLE AVE BOWIE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension and</u> DUE TO (c) <u>arterio sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 6, 1956</u> , to <u>Dec 21, 1956</u> , that I last saw the deceased alive on <u>Dec 20, 1956</u> , and that death occurred at <u>2:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Buell</u>				ADDRESS (Street, city or town, state) <u>402 Main St - Laurel Md.</u>			
PHYSICIAN'S NAME (Type) <u>John R. Buell M.D.</u>				DATE SIGNED <u>12/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Collington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John G. Gingles</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10a, 11, 13, 14 FilmG208 12-20-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12859

12820

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Md</u>				c. LENGTH OF STAY IN 1b <u>3 Mo 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>				d. STREET ADDRESS <u>Westie & Reed St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Roseanna F.</u> Middle <u>Winston</u> Last <u>Winston</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-1909</u>	9. AGE (In years lost birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Orange, Virginia</u>		
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Robert Turner</u>				14. MOTHER'S MAIDEN NAME <u>Katie Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple sclerosis</u> <u>345x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>56</u> , to <u>12/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>56</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John K. Abre</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesley, Md.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CARVER MEM</u>		22d. LOCATION (City, town, or county) _____ (State) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FRAZIER FUNERAL HOME RI</u>				24a. RECEIVED BY REGISTRAR DATE <u>DEC 17 56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
 DEC 17 1956
 BUREAU V. S.

FRANKLIN TOWNSEND
 11/12/56
 11/12/56

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
PREVIOUS MARRIAGES		PREVIOUS DEATHS	
FAMILY HISTORY		SOCIAL HISTORY	
HISTORICAL DATA		PHYSICAL DATA	
MENTAL DATA		PATHOLOGICAL DATA	
LABORATORY DATA		RADIOLOGICAL DATA	
TREATMENT DATA		SURVIVAL DATA	
FOLLOW-UP DATA		REMARKS	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 18 Film 210 2-11-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12874

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Northern Avenue			d. STREET ADDRESS Northern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Walter Middle Wholard Last Wholard			4. DATE OF DEATH Month Dec. Day 13, Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1902	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Jewelry		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James T. Woolard			14. MOTHER'S MAIDEN NAME Josephine Carneal		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 6503 Falling Creek Circle, Rose Humphrey, Richmond, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 892.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon monoxide poisoning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-14-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 21 1956	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BILTMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		James T. Woodard	
Sex		Male	
Race		White	
Age		40	
Date of Birth		Jan. 22, 1902	
Place of Birth		Virginia	
Usual Residence		Jewelry	
Cause of Death		Lung Disease	
Place of Death		Home (Temporary), Baltimore, Md.	
Occupation		Jewelry	
Signature of Physician		James T. Woodard	
Signature of Medical Examiner		John T. McManis, M.D.	

BUREAU V. 2
 DEC 21 1956
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12875 BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

12861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>805- Addison Rd.</u>				d. STREET ADDRESS <u>5805- Addison Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>DENZIL</u> Middle <u>ROY</u> Last <u>YOUNGS</u>				4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>			
11. BIRTHPLACE (State or foreign country) <u>Union County, Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Curtis Frost Youngs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>327-10-5803</u>			
17. INFORMANT <u>Earl Lee Youngs</u>				Address <u>5805 Addison Rd. Seat Pleasant, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with myocardial degeneration</u> DUE TO (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 1, 1953</u> to <u>Dec. 2, 1956</u> , that I last saw the deceased alive on <u>Dec. 2, 1956</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>12/2/56</u>							
ACTUAL SIGNATURE <u>William Brainin M.D.</u>				PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlaine</u> ADDRESS <u>517-11th St. N.E.</u>				24a. REC'D BY REGISTRAR <u>DEC 4 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>							

12821

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rogers Heights,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2601 Cheverly Avenue</u>				d. STREET ADDRESS <u>4922--56th Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>(N.M.N.)</u> Middle <u>YURWITZ</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>31st</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26th, 1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Kadina, Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>J. Peter Yurwitz, 6216 Kilmer St. Cheverly</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous small strokes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1 Jan., 1953</u> to <u>30 Dec., 1956</u> , that I last saw the deceased alive on <u>29 Dec., 1956</u> and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3404 Cheverly Ave., Cheverly, Md.</u> DATE SIGNED <u>12/31/1956</u>							
ACTUAL SIGNATURE <u>John Kehoe</u>				M.D. <u>3404 Cheverly Ave., Cheverly, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John Kehoe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Raymond's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bronx, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7 57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Kehoe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

RECEIVED

BUREAU V. 3

12876

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>VAINT BRANCH Nursing Home</u>		d. STREET ADDRESS <u>6325 RIVERDALE AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIA THERESA ZILCH</u>		4. DATE OF DEATH Month Day Year <u>12 14 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 27, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN P. WOLF</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET M. FENN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HELEN ZILCH - 6325 Riverdale Ave RIVERDALE MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u> <u>40+ years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>THROMBOSIS RIGHT POPLITEAL ARTERY (10/19/56)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/12</u> , 19 <u>49</u> , to <u>12/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>56</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Louis Mendel</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4506 COLLEGE AVE</u> <u>12/14/56</u>	
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL</u>		<u>COLLEGE PARK MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-17-56</u>	<u>St. Luke Lutheran Church</u>	<u>Crown Point Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Son - Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 19 1956

RECEIVED

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12822

CERTIFICATE OF DEATH

Reg. Dist. No.

12864

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly MD				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale Md.			
				f. STREET ADDRESS 5509 59th Ave			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle Zmavuski Last 				4. DATE OF DEATH Month Dec Day 15 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 19 1881	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Sereika				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph J. Zane Address 5509-59th Ave. East Riverdale Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular renal disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic coronary infarction, diabetes mellitus, hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April , 19 56 , to 12/15 , 19 56 , that I last saw the deceased alive on 12/14 , 19 56 , and that death occurred at 2:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Julius Gauffman M.D.				ADDRESS (Street, city or town, state) Bladensburg, Md. DATE SIGNED 12/15/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Dec. 18, '56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. ADDRESS 5801-Cleve. Ave. Riverdale Md.				24a. REC'D BY REGISTRAR DATE DEC 19 56		24b. REGISTRAR'S SIGNATURE Deitch	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF WITNESSES	
JAMES EARL RAY		M		35		W		JAN 5, 1928		MEMPHIS, TENN		JAN 6, 1968		MEMPHIS, TENN		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
14. MARITAL STATUS		15. OCCUPATION		16. EDUCATION		17. RELIGION		18. PREVIOUS MARRIAGES		19. PREVIOUS DEATHS		20. PREVIOUS INMATE		21. PREVIOUS MENTAL		22. PREVIOUS PHYSICAL		23. PREVIOUS DRUGS		24. PREVIOUS ALCOHOL		25. PREVIOUS TOBACCO		26. PREVIOUS OTHER	
MARRIED		LABORER		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
27. PREVIOUS ARRESTS		28. PREVIOUS CONVICTIONS		29. PREVIOUS SENTENCES		30. PREVIOUS PAROLE		31. PREVIOUS PROBATION		32. PREVIOUS JAIL		33. PREVIOUS HOSPITAL		34. PREVIOUS SURGERY		35. PREVIOUS MEDICATION		36. PREVIOUS TREATMENT		37. PREVIOUS DIAGNOSIS		38. PREVIOUS PROGNOSIS		39. PREVIOUS OUTCOME	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
40. PREVIOUS DEATHS		41. PREVIOUS INMATE		42. PREVIOUS MENTAL		43. PREVIOUS PHYSICAL		44. PREVIOUS DRUGS		45. PREVIOUS ALCOHOL		46. PREVIOUS TOBACCO		47. PREVIOUS OTHER		48. PREVIOUS TOBACCO		49. PREVIOUS OTHER		50. PREVIOUS TOBACCO		51. PREVIOUS OTHER		52. PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
53. PREVIOUS TOBACCO		54. PREVIOUS OTHER		55. PREVIOUS TOBACCO		56. PREVIOUS OTHER		57. PREVIOUS TOBACCO		58. PREVIOUS OTHER		59. PREVIOUS TOBACCO		60. PREVIOUS OTHER		61. PREVIOUS TOBACCO		62. PREVIOUS OTHER		63. PREVIOUS TOBACCO		64. PREVIOUS OTHER		65. PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
66. PREVIOUS TOBACCO		67. PREVIOUS OTHER		68. PREVIOUS TOBACCO		69. PREVIOUS OTHER		70. PREVIOUS TOBACCO		71. PREVIOUS OTHER		72. PREVIOUS TOBACCO		73. PREVIOUS OTHER		74. PREVIOUS TOBACCO		75. PREVIOUS OTHER		76. PREVIOUS TOBACCO		77. PREVIOUS OTHER		78. PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
79. PREVIOUS TOBACCO		80. PREVIOUS OTHER		81. PREVIOUS TOBACCO		82. PREVIOUS OTHER		83. PREVIOUS TOBACCO		84. PREVIOUS OTHER		85. PREVIOUS TOBACCO		86. PREVIOUS OTHER		87. PREVIOUS TOBACCO		88. PREVIOUS OTHER		89. PREVIOUS TOBACCO		90. PREVIOUS OTHER		91. PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
92. PREVIOUS TOBACCO		93. PREVIOUS OTHER		94. PREVIOUS TOBACCO		95. PREVIOUS OTHER		96. PREVIOUS TOBACCO		97. PREVIOUS OTHER		98. PREVIOUS TOBACCO		99. PREVIOUS OTHER		100. PREVIOUS TOBACCO		101. PREVIOUS OTHER		102. PREVIOUS TOBACCO		103. PREVIOUS OTHER		104. PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	

RECEIVED
DEC 19 1956
BUREAU V. 3